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**KNOWLEDGE, POWER, AND NURSING EDUCATION
IN NEW ZEALAND: A CRITICAL ANALYSIS OF THE
CONSTRUCTION OF THE NURSING IDENTITY**

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ABSTRACT

Formalised nursing education programmes in hospitals which lead to registration as a nurse commenced in New Zealand following the enactment of the Nurses Registration Act 1901. This system of education, which continued for some seventy years, constructed the nursing identity within the discourses of gender and medicine. The relocation of nursing education into the tertiary education sector which commenced during the 1970s disrupted this dominant view of the nurse.

This thesis describes and critically analyses the construction of the nursing identity through curriculum and social relations of power. Michel Foucault's view of power and his power/knowledge problematic is a major component of the critical analysis. The analysis draws heavily on the work of Foucault to unmask power relations which discursively position the nurse in the discourses of medicine and gender. Foucault's notion of governmentality is used to illustrate the existence of technologies of domination and technologies of power which discursively constitute the nurse. New forms of knowledge construct the nursing identity through different discourses. The insights of critical theorists are employed to illustrate the influence of the emancipatory intent of these discourses. Sociopolitical forces which intersect with nursing education act to subjugate knowledge not associated with the dominant view of nurse and nursing. Perceptions continue to exist that nurses and nursing are associated with technical activity.

Despite the struggle for the nursing profession to define the nurse according to how it sees appropriate, there are micropolitics of power which operate to sustain the dominant view of nurses. However, nurses implicate themselves in the creation of their subjectivity, and are themselves agents in creating their own identities. This suggests that there are possibilities for the nurse to resist being defined by others.

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SECTION ONE

INTRODUCTION

This first section of the thesis comprises three chapters. Chapter one provides an introduction and background to the context, issues and questions with which this thesis is concerned. It also provides an outline of the twelve chapters into which the thesis is structured.

Chapter two presents information about previous studies relating to nursing and nursing education which helps place the issues and questions of this thesis into a context.

Chapter three outlines issues in methodology. As this thesis represents a critical study of how the occupational identity of the nurse is constructed, the critical framework employed to analyse this is necessarily broad. Although the analysis throughout the thesis draws heavily on the insights and ideas of the work of Michel Foucault in relation to knowledge and power, the work of other critical writers, such as Jurgen Habermas, Paulo Freire and Brian Fay are significant to the broad critical perspective of this thesis. Thus the focus of chapter three is to provide an explanation of how the work of these writers relates to the argument of this thesis.

CHAPTER ONE

INTRODUCTION AND OVERVIEW

This thesis explores the construction of the occupational identity of the nurse in terms of a critical analysis of issues of knowledge and power associated with nursing education in New Zealand. It presents as an overarching argument, that the nurse is discursively positioned within various discourses which shape and construct the nurse as a particular occupational identity. This identity has been forged between at least two major forces. First the influence of legislation which defines and prescribes the requirements to become a nurse, and second, the nursing profession which has sought to shape and develop the nurse as it sees appropriate. Within this thesis, influences, tensions and struggles associated with these forces are identified and analysed to illustrate how complex processes of knowledge and power relationships operate to construct the nurse. The first chapter provides an overview of the context, issues and questions in which the thesis is developed, and concludes with an outline of the structure of the thesis.

The context of the thesis

Within health systems a particular type of activity referred to as nursing is provided by a specific group of people, referred to as nurses. The concept of *nurse* is both a social and historical construct, and in New Zealand has a legal status. In this country nurses are legally able to be called such by virtue of having their name entered on a Register of Nurses or a Roll of Nurses administered by the Nursing Council of New Zealand. It is an offence for individuals in New Zealand to refer to themselves as a nurse unless they are a registered nurse or an enrolled nurse. This is stated in the Nurses Act 1977, Section 52 (2) as:

... every person, who, not being registered or enrolled, takes or uses the name or title of nurse, either alone or in combination with any other words or letters, with intent to cause any other person to believe that he¹ is specially qualified to practise nursing or any class of nursing, commits an offence and is liable on summary conviction to a fine not exceeding \$1,000.

Implicit in this statement is that in order to become a nurse there is a requirement to undergo some sort of process which results in a qualification. A further implication is that it is necessary to be a nurse to practise nursing, with at least two categories of nurse able to be identified - registered and enrolled.

Legislation regulating the process of becoming qualified as a nurse was first enacted in New Zealand in 1901. The emergence of registered nurses as a group of qualified health practitioners followed the enactment of the Nurses Registration Act 1901. The purpose of this Act was not simply to register nurses but additionally to establish standards for the training of nurses in New Zealand. To become a nurse and have their name entered on the register of nurses, individuals had to undertake a period of three years' consecutive training, with theoretical instruction, and were required to pass a national examination. Some ninety years after the enactment of this first statute, to achieve registration as a nurse in New Zealand involves virtually the same statutory requirements. Yet despite the similar requirements to become a registered nurse, the process and content of nursing education is very different from

¹ The term "he" is used throughout the Nurses Act 1977. Section 2 (2) of this Act, however, states that "Words importing a gender in any enactment, and referring to a registered nurse or an enrolled nurse or to a person seeking to become a ... nurse shall, unless the context otherwise requires, be read as if they also import the other gender".

The Nurses Registration Act 1901 referred to nurses as "she". This is also the case for the Nurses and Midwives Registration Act 1925. It appears that the term "he" was introduced into nursing legislation in the Nurses and Midwives Act 1945. This Act provided for the registration of psychiatric nurses and male nurses, which may account for the change in terminology.

how it was at the beginning of this century. For around seventy years nurses were 'trained' within a hospital environment. During the 1970s a major change occurred. Nursing education commenced preparing registered nurses within the mainstream education system. A new 'type' of registered nurse was envisaged. This was a comprehensive nurse who was to be able to work in all areas of health care, rather than being trained specifically to work in one hospital area. The enactment of the Education Amendment Act 1990 had a further effect on nursing education, in that polytechnics with nursing courses were empowered to confer degrees in nursing.

Thus the construction of a different nurse from that which had been essentially unchanged for some seventy years provides the context for the questions and issues which are central to this thesis. Although the main focus of this thesis is nursing education which prepares individuals for registration as nurses in New Zealand, it is not limited to this. In order to unravel the complexity of social, political and educational elements that have shaped and influenced the nurse and nursing education, it is necessary to move between the past and the present. This thesis does not, therefore, follow a pattern which begins at one point in time and ends at another.

Essentially this thesis asserts that the nurse is discursively constituted within various discourses; in particular, the dominant discourses of gender and medicine, and that changes to the system of nursing education disrupted this. The key elements in this disruption involved the relocation of nursing education into a new location, as well as a different curriculum, both of which were intended to effect the construction of a different nursing identity positioned outside the dominant discourses of medicine and gender. This thesis also argues that the nurse is also an agent of her own construction within other discourses which differ from these discourses, and that there are possibilities for resisting being defined by others.

The subject: 'nursing identity'

In undertaking a critical analysis of nursing education and the construction of a nursing identity it could be seen that there seems to be a suggestion that *nurse* means one identity. The notion of subject is used here in the sense of "the person, individual or human being ..." (Henriques et al, 1984:2). Implicit within this definition are notions of the "self" and "identity", and in this thesis, the nurse-subject is an occupational identity. Since what nurses do is nursing, the subject is referred to as the nursing identity. Although the notion of identity is used from a singular perspective, it needs to be made clear that this is for convenience in this thesis. There are nursing 'identities' in the plural sense that a number and range of nurses exist.

In this thesis the nursing identity is referred to throughout as 'she' or 'her'. This is because any privileging of the notion of 'he' is rejected on the basis that nursing is primarily associated with women, and although the word nurse should imply no connotation of gender, it does, because of its history. Additionally, since there are aspects of the position of the nurse that exist because of gender discourses, it is central to the argument of this thesis to reveal rather than conceal the embeddedness of the nursing identity within a gender context.

Throughout this thesis the construction of the subjectivity of the nurse refers to "... the conscious and unconscious thoughts of the individual, her sense of herself, and her ways of understanding her relationship to the world" (Weedon, 1987:32). Subjectivity then, refers to the condition of being a subject - always positioned in relation to particular discourses and the practices produced by these discourses (Henriques et al, 1984).

The occupational identity of the nurse is influenced by several institutions of society; the most readily identifiable of which are law, health and education. Within these institutions the subjectivity of the nurse is constituted. In terms of the law, the nursing identity exists by statute as a legal identity. This is determined according to the Register of Nurses, which according to the Nurses Act 1977, Section 16 (a) consists of seven parts, which relate respectively to

- (i) Registered comprehensive nurses;
- (ii) Registered general nurses;
- (iii) Registered general and obstetric nurses;
- (iv) Registered midwives;
- (v) Registered obstetric nurses;
- (vi) Registered psychiatric nurses;
- (vii) Registered psychopaedic nurses.

In addition to the Register of Nurses, onto which the names of those who meet the requirements for registration as a nurse are entered, is a "Roll of Nurses", Section 16 (b) which makes provision for another category of nurse - the enrolled nurse. Over a period of nearly one hundred years in New Zealand's history these categories have developed in accordance with various health needs of society.

What is investigated in this thesis then, is the power relations associated with law, the health and education systems and how their various discursive practices and discourses influence and shape the occupational identity of the nurse. Essentially this investigation commences from when the nurse became a legal subject through the enactment of legislation which provided for one category of nurse - a registered nurse, to the present situation of some eight different categories of nurse.

Nursing education in New Zealand

Formalised nursing education or 'training' nurses in New Zealand commenced at a time when society was entrenched in Victorian principles of morality and when definite views existed about the role of women. It developed from the Florence

Nightingale model of nursing which commenced in her training school for nurses, founded in 1860 at St Thomas's Hospital in London (Abel-Smith, 1960). In the early days of nursing in New Zealand, a strict regime of discipline was imposed on both trainees and nurses to ensure the internalisation of implicit obedience to their 'superiors' which included more senior nurses as well as medical practitioners. (Rogers, 1985). In its early days nursing education was concerned with the morality and conduct of nurses. In order to be accepted as a legitimate occupation, nursing struggled for social acceptability (O'Brien & Watson, 1993). The nursing role was associated with notions of passivity, docility, servitude, obedience and subservience to the medical profession. It is not difficult to imagine why nursing education in its early days might have struggled to articulate anything other than obedience and assistance to the medical profession as the basis for the existence of the nurse. The nursing identity was initially constructed by powerful medical and gender discourses, and in these discourses the dominant ideologies of society are enshrined (Delacour, 1991).

But nursing² has sought to establish itself outside these discourses; as a profession in its own right, and different from the way it was viewed at the beginning of this century, particularly in terms of its knowledge base. Changes within the last twenty five years reflect the fact that the nursing profession perceives nursing in a different way from its traditional beginnings as an adjunct to medicine. Perhaps more importantly, these changes reflect altering trends in the way that the education of nurses is viewed as needing to produce practitioners who can function differently from the registered nurses who were influenced throughout their training by medical and gender discourses. By this is meant a shift in emphasis from nursing as the acquisition of skills to a more broadly based view of nursing as an activity

² Reference throughout this thesis to this term refers to the occupation of nursing and includes individuals and groups who collectively represent the interests of nurses.

which also requires critical thinking activities applicable in a range of health care settings, and an emphasis on professional practice.

Two main shifts have occurred in nursing education, and it is argued that these have disrupted the dominant view of the nursing identity discursively constituted by gender and medical discourses. The first of these is the transfer of nursing education from hospitals to polytechnics. This occurred as a result of the *Carpenter Report* of 1971 - a report which essentially provided the catalyst for a major change in the way that nursing education was both considered and delivered. It culminated in a shift from a hospital based apprentice system of training individuals to be nurses to a system of nursing education located in polytechnics within the tertiary education sector. But the change of learning environment was not the only difference. The focus became different. It shifted to student based learning and preparation for registration as *comprehensive* nurses - a shift which meant that nurses were now being prepared to provide care in a variety of health care settings. Not only therefore, did the 'product' of nursing education change, so too did the process. Previously, nursing students within a hospital environment were employees attached to a particular school of nursing, where theoretical aspects of nursing were undertaken through a system of study days and block lectures, and clinical experience where students, as employees, learned 'on the job'. The change to the tertiary education environment established a three year course of study comprising an even distribution between theory and clinical experience. Theoretical aspects of the course occurred within the polytechnic environment and placements in hospitals and various community settings provided clinical experience. Students were no longer employees of an organisation paid while learning about nursing, but had student status within the education system.

The second shift in nursing education resulted from the enactment of the Education Amendment Act 1990 which empowered polytechnics to confer degrees in nursing. In 1992, three polytechnics³ commenced undergraduate degrees in nursing - Auckland, Wellington and Otago. By 1995 all of the fifteen polytechnics in which comprehensive nursing courses have been provided had either commenced undergraduate degrees in nursing or had made application to do so. In 1997 all these polytechnics offer degrees as entry level to practice as a comprehensive nurse (Nursing Council of New Zealand, 1997).

Different views about nurses and nursing

Changes in nursing education have not been either straightforward or easy. There are several possible reasons for this. Most people hold a personal view of what a nurse is and what a nurse does. This may be influenced by a person's individual experience of nurses, but it can also be influenced by media images of nurses and nursing in which nurses and nursing are portrayed differently from the reality (Muff, 1984; Kalisch and Kalisch, 1987). It is hardly surprising if public perceptions of nurses and nursing differ from the perception that nurses have of what they do as nurses and what nursing is in terms of the real world of nursing. It can be argued that Florence Nightingale's legacy of duty, obedience and servitude persists in public perceptions of nursing and nursing education, as well as a view that as nursing exists as an adjunct to medicine, then the knowledge basis for nursing is derived from an association with medicine. That these perceptions about nurses and nursing continue is an essential component of the overarching argument of this thesis.

³ The term polytechnic is used to represent those organisations within the tertiary education sector providing comprehensive nursing courses. Some are called by different names, for example *Auckland Institute of Technology*.

Through an examination of specific critical historical incidents associated with nursing education, therefore, it is possible to determine that struggles to initiate change to nursing education (and by implication, the nursing identity) have taken place at various times in New Zealand. As noted by Marie Burgess (1984:60)

The formal preparation of nurses in this country has had an interesting and at times troubled history. Controversy and struggle have always surrounded change in nursing education. The reasons for this are many and varied but must include traditionalism and conservative attitudes within the nursing profession itself. At times resistance from a male-dominated medical profession has not aided an equally female-dominated nursing profession improve the educational status of its members ... Such a large professional group has a high public profile, and the general public have at times been a vocal part of the controversy and struggle toward change in nursing education.

The essence of issues with which this study is concerned is captured in this quotation. That is, that complex social and political factors associated with gender and medical discourses influence the nursing identity through nursing education processes.

Nursing education is considered to have a particular function, which according to The New Zealand Nurses' Organisation (1993:2), is to

...enable potential and practising nurses to develop the knowledge and skill required to fulfil the profession's commitment to society and to develop nursing to enable the future health needs of society to be met with innovation and confidence.

This definition has been used here to illustrate that nursing education does not necessarily end once an individual becomes a nurse through the completion of a programme or course of education leading to registration or enrolment as a nurse. However, in fulfilling its obligation to society to prepare a particular type of health professional for practice as a beginning practitioner, nursing education has had to demonstrate that it has done this through the transmission of a specific set of

institutional knowledge practices which determine what counts as knowledge (Fraser, 1989). In this respect the nursing identity is shaped by curriculum. The products of nursing education - registered nurses⁴ - are developed by nursing deferring to its own concepts to authorise its claims to truth and its identity in relation to knowledge. But the genesis of truth claims or the 'regimes of truth' associated with nursing knowledge need to be examined in order to understand the construction of the nursing identity at various times throughout the relatively brief history of the nurse in New Zealand. Nursing as an occupation seeking to attain professional status has struggled to make meaning out of its identity through attempting to define (and redefine) its knowledge base. But as far as dominant social perceptions of nursing are concerned, a nurse fits within one or more stereotypes about what a nurse *is* and what a nurse *does*. Among and between nurses there are disparate views; this is most apparent in nurses working in nursing education and nurses working in practice. This results in several different points of view about the way that nursing and nurses are defined by nursing itself. Two important aspects of this thesis, therefore, are ontological and epistemological issues in relation to what 'is' in terms of the nursing identity and the knowledge base considered necessary for the nurse to have. These will be explored through the notions of curriculum and knowledge, where it can be seen how this is determined.

Questions and issues

Crucially important matters arise in challenging the ontological and epistemological bases of nursing and the nursing identity. Although the focus of this thesis is primarily on how the nursing identity is constructed, the question what is a nurse? underpins issues addressed in this thesis. In order to determine if this question is

⁴ The emphasis in this thesis is on the preparation of registered nurses, although the relationship between enrolled nurses and registered nurses in the broader context of nursing will become apparent in later chapters.

possible to answer, several other questions become important. These are:

- What is a nurse in terms of knowledge?
- How was it decided what knowledge was included in the education of nurses?
- Who continues to decide what knowledge will be included in nursing education?
- What is nursing in terms of the way nurses are educated?
- What is the relationship between nursing education and the nursing identity?

The answers to these questions emerge in various points of this thesis. In particular, what will be illustrated is that within the last twenty-five years, nursing has sought to establish itself as a profession and a discipline by endeavouring to establish a base of knowledge about and for nursing. This becomes particularly apparent in various iterations of the curriculum used for nursing education programmes. These epistemological considerations and searches for the 'truth' about nursing in terms of what a nurse is and what a nurse does have not provided or established an accepted or consensual definition of nursing. Rather these activities have demonstrated the diversity of nursing and that nurses and nursing cannot be described and defined in a singular manner. Hence there can be no doubt that the notion of the nursing identity must be considered as multiple. And perhaps more importantly, an array of different discourses have developed in efforts to define and describe nurses and nursing.

Curricula and nursing education

The nursing curriculum is an important aspect of this thesis, since it has a crucial role in the construction of the nursing identity. For many years the nursing

curriculum was prescribed in terms of the specific content and number of hours for particular areas within the total programme.⁵ With the introduction of comprehensive nursing courses and more recently, with the establishment of undergraduate degrees in nursing, curricula have undergone change. This change has been influenced by many factors, but in particular, changing views of knowledge and different educational ideologies which affect nursing education as a whole, have in turn led to changes in the aims of curricula and their design. While the transfer of nursing education into the tertiary sector during the 1970s brought about a change in the approach to teaching students of nursing, the curriculum design was one based on a behaviourist model which was heavily influenced by the work of Ralph Tyler (1949). Although Tyler's work in the United States was associated with school curricula, it was adopted by the National League for Nursing in the United States during the 1960s, as the basis for approval and accreditation of nursing education curricula in that country. Additionally, North American nurse educators, in particular Bevis (1973), adopted Tyler's model to develop nursing education textbooks to guide nurse educators in curriculum planning. Nurse educators from New Zealand who studied in North America were in turn influenced by such literature (Christensen, 1989).

In Tyler's (1949) curriculum model, prescriptions of precisely what was to be learned and how what had been learned would be measured, formed the basis of curricula. This influence in nursing education will be explored in some depth. The commencement of undergraduate degrees, in line with international nursing education literature and trends in health care issues, created an opportunity for the

⁵ This took the form of instructions developed pursuant to various Nurses Registration Regulations. For example the *Supplementary Instructions for the Training of Nurses* issued by the Nurses and Midwives Board under the Nurses and Midwives Act 1945 prescribed the requirements for nursing education programmes during the 1960s immediately prior to the first shift in nursing education.

introduction of a different curriculum model from the behaviourist model. This different approach has been termed a transformative curriculum model,⁶ described in this way since it is considered to be one which essentially embraces the principles of social criticism. Such an approach to the education of nurses is considered by nurse educators and nurse scholars to be necessary to address the complexity of knowledge associated with nursing as well as enabling the development of critical thinkers who need to make professional judgements in practice environments where nurses interact with a multitude of different people with a variety of health needs (Bevis and Watson, 1989). A brief examination of nursing education curricula is undertaken in this thesis to determine if this view is reflected, and in terms of how conceptions of occupational identities are established. It is also increasingly argued by nurse scholars that nursing is considered to be a practice discipline, and that knowledge is embedded in nursing practice (Carper, 1978; Benner and Wrubel, 1982; Benner, 1983, 1984). Both the content and process of nursing education curricula need to be analysed to determine if this is reflected in expectations of students of nursing throughout a nursing education course.

A difficulty for nursing education, however, in introducing any change either to the process or content or indeed the introduction of new knowledge into a curriculum seems to be that it leads to public expression of concern about nursing education which is unprecedented in any other form of vocational education. The most recent example is the concept of *cultural safety* introduced into nursing curricula by the Nursing Council of New Zealand in 1991 as a specific requirement for nursing education courses. As it will be identified in chapter nine, publicity and media

⁶ This is able to be identified in the National League for Nursing's 1988 publication *Curriculum Revolution: Mandate for Change* in which several nurse educators (for example, Bevis, Watson, Diekelmann), argue for the need for a different curriculum model for nursing education which will produce practitioners who are critical thinkers able to use theory to guide their practice and reflect on practice to develop theory.

attention given to one student from one polytechnic's comprehensive nursing education course in 1993 resulted in what could be described as frenzied statements from members of the public about what was and was not appropriate for nursing education. During 1995 the issue of cultural safety again became predominant in the media and accusations were levelled at the Nursing Council about the appropriateness of the inclusion of this concept in nursing education courses.

As a result of the intense interest in the notion of cultural safety and its appropriateness in nursing education between 1993 and 1995, in July 1995 a select committee of the New Zealand Parliament began an enquiry into the teaching of cultural safety (Revell, 1995). The debate surrounding cultural safety highlights the range of beliefs and assumptions in society about nurses and nursing which influence people's perceptions about both educational processes and the content of nursing education courses. It also demonstrates the influence of the media in relation to public perceptions of nursing. Perhaps most importantly, however, it illustrates the continuing struggle that nursing education has in its efforts to prepare safe and competent practitioners to practise nursing in New Zealand society. It is a striking example of the tension that exists between nursing and society in a struggle for professional respectability (O'Brien & Watson, 1993). The public debate which surrounded the introduction of cultural safety into nursing education illustrates two key themes in this thesis - knowledge and power and the influence of social and political factors on nursing and nursing education in New Zealand. But it also raises important issues in relation to how the content of nursing education curricula is determined. Changes to nursing education systems and curricula reflect that the nursing profession has particular beliefs and values about what a nurse is and should do in relation to the practice of nursing. This is illustrated in the emergence of new discourses which nurses utilise in an effort to position the nurse as a different practitioner from the one which was constructed in the early days of

nursing education in New Zealand. But these discourses also have their own discursive practices, and these subject the nurse identity in ways which are not always acknowledged or understood. While it can be seen that the nurse is created and governed through regulatory processes of statutory control the nurse also implicates herself in processes of governance, hence the interrelationship between knowledge and power exists in different forms. This also illustrates how the nursing identity is discursively constituted.

Since the commencement of the transfer of nursing education to polytechnics, there have been accusations that graduates of comprehensive nursing courses are inadequately prepared to meet the realities of practice and to meet the needs of employers (Grigg, 1982; Eisig, 1991). Such accusations would appear to reflect differing perceptions about nurses, nursing and nursing education between and among nurses as well as between nurses and society in general. Although the New Zealand Qualifications Authority ⁷ specifies a requirement for consultation with a variety of groups which includes the local community, the extent of this consultation may not provide an appropriate mechanism for expounding the intent of nursing education courses. Changes in the nursing identity through changed nursing education appear to be at the very least misunderstood. It may not be possible to identify with any certainty what the public's involvement is or has been in any planned change to systems of nursing education. One possibility is that the survival of nursing as an occupation takes precedence over any consultation with the public in times of change.

⁷ The New Zealand Qualifications Authority (NZQA) has statutory responsibility for the approval of degrees in Polytechnics and accreditation of such institutions to offer degrees. The role of NZQA will be discussed in chapter eight.

The nursing education system which prepares individuals for registration as nurses in New Zealand had its origins in the Florence Nightingale model in terms of an apprenticeship system of training in hospitals with strict emphasis on moral character and obedience. Other countries, most notably the United Kingdom, North America and Australia, share this origin, but nursing education has developed differently in each of them. So although there are clear similarities in nursing education programmes, the way in which they are organised, located and delivered, makes each country distinctly different. While there has been research undertaken about nursing education in overseas countries, most studies are not relevant to the New Zealand situation because they are concerned with different issues and different systems (Maggs, 1983, Russell, 1990). That does not mean this literature is not addressed in this thesis. Rather, in keeping with the methodology used, this literature will emerge throughout as various issues and questions are addressed. However, in order to provide a focus for the context of this thesis a literature review of the historical discourse of nursing education and practice in New Zealand is provided in chapter two.

As chapter two will illustrate, the existing historical discourse provides a useful background of information about nursing education from several different perspectives. It highlights a perceived gap between the reality of nursing practice and nursing education in terms of the end product of nursing education - the registered comprehensive nurse. But essential questions remain unanswered in the relationship between nursing education and the nursing identity. Underpinning these questions is the issue of how nursing education is controlled, how the knowledge base for nursing education is determined, as well as how the direction that nursing education takes in preparing registered nurses for practice is determined. This thesis therefore approaches these questions from a methodological perspective which critically analyses the past and present of nursing education in

terms of the issues of knowledge and power networks which influence the way in which the occupational identity of the nurse is constructed.

Structure of the thesis

Underpinning the argument of this thesis is that what is at issue in any relationship between nursing education and the nursing identity is the network of power/knowledge relations and discourses within which certain regimes of truth can be identified. Within this network of power/knowledge, the nurse is shaped and reshaped through *dispositifs*⁸ of discourse/practice. Thus the socio-political context of nursing education is a significant factor in how the nurse is discursively constructed. Each chapter identifies aspects and themes which substantiate this claim.

The thesis is presented in twelve chapters, and in three sections. Section One is an introduction to the thesis, and contains three chapters. **Chapter One** provides an overview of the thesis in terms of the context, themes and issues of concern. **Chapter Two** provides a review of the literature, which will illustrate in particular, different approaches to the study of nursing education. It also identifies the existence of socio-political issues apparent in nursing education and nursing practice, which emphasise the need for further exploration. **Chapter Three** addresses the framework for analysis in this thesis, where the insights of Michel Foucault as well as those of other critical theorists will be discussed in terms of their relevance to the argument of this thesis.

⁸ This is a term used by Foucault which essentially means apparatus. It captures the way in which the will to knowledge inscribed in the technical apparatus of society creates subjects through power relations co-ordinated in relationships with knowledge systems. (Ingram 1994).

Section Two comprises five chapters which focus on the process and content of nursing education. **Chapter Four** essentially examines how the nursing identity was initially constructed in the discourses of gender and medicine through the importation of the Florence Nightingale apprenticeship model of training and how this influences perceptions of nurses in the present. **Chapter Five** examines how the shift in the location of nursing education from the hospital system to the tertiary education system was effected, and how perceptions of nurses and nursing were challenged. It also illustrates the way in which nursing education was controlled through various mechanisms of power. **Chapter Six** examines curriculum issues, but in particular, nursing education curricula which reinforced the discourses of medicine and gender, and emphasised the skill base of nursing. **Chapter Seven** explores and analyses knowledge, truth and power in relation to nursing and nursing education. In particular, definitions of nursing which can be seen as both constraining and liberating are critiqued. **Chapter Eight** examines a further shift in the nursing identity with the commencement of undergraduate degree programmes in nursing in three polytechnics in 1992. It explores the notion of “curriculum revolution” which had an influence on changes to the nursing education curriculum in New Zealand, and hence the potential to shape a different nursing identity.

Section Three explores notions of an emerging identity which is driven by the nursing profession, and identifies tensions that exist in relation to this. **Chapter Nine** examines the intent of the notion of *cultural safety* in terms of its introduction into nursing education courses and the subsequent controversy and unintended consequences which resulted from its inclusion in curricula. This provides a particular example of how tensions arise when the nursing profession attempts to introduce new concepts into the education of nurses. **Chapter Ten** examines the regulation and statutory control of the nurse, and explores the notions of

professionalism and professional closure as essential components in the construction of the nursing identity. **Chapter Eleven** provides an analysis of emerging discourses in nursing, and focuses on how the nursing identity continues to be shaped by technologies of the self. **Chapter Twelve** concludes the thesis, and explores possibilities for resistance in the construction of the nurse and (re)positioning the nurse in a dynamic health environment characterised by tensions and ambiguities.

CHAPTER TWO

HISTORICAL DISCOURSES

This chapter presents an overview of the literature in relation to nursing education. It provides the reader with information about previous studies, with a particular emphasis on New Zealand studies. This is done to place this thesis into the context of nursing education in New Zealand. The relationship between nursing education and its 'product' - the nurse - is an area in which there has been little formal research undertaken, and about which there is a paucity of New Zealand published literature. As identified in the introduction to this thesis, since nursing education was transferred from hospital schools of nursing into schools of nursing in polytechnics, there have been suggestions that comprehensive nursing courses do not adequately prepare nurses for the realities of clinical practice, nor the needs of employers of registered nurses. It is useful, therefore, to review the literature in order to gain an overview of what research exists to identify if such assertions have any legitimacy.

International literature

While there has clearly been research conducted in other countries about nursing and nursing education, the findings of such studies may be limited in the context of nursing and nursing education New Zealand. However, some relatively recent overseas studies have relevance to this thesis in that they illustrate some of the issues with which this thesis is concerned. They are also useful in the provision of a background of the way the nurse has become positioned in society. In addition, early nursing and nursing education in New Zealand has been influenced by British nurses, in particular Florence Nightingale and nurses who trained at her training

school in London. This is also the case with nursing education in America and Australia, where early nursing was influenced by the importation of nurses trained in the Nightingale system.¹

Christopher Maggs (1983) in his historical study of *The Origins of General Nursing* provides a comprehensive overview of the emergence of the trained nurse in Britain, between 1881 and 1914. His study traces the emergence of what he refers to as “the first generation of general trained nurses in England” (Maggs, 1983:1) to show how they came to dominate nursing in England, collectively as a new order. He notes general hospital nurses were those nurses who either worked in, or were trained in various hospitals which existed in England during this period. He is careful to point out that prior to 1919, when the English Nurses Registration Act was enacted, there was no legal definition of a nurse. However, this did not prevent those persons who had undertaken some form of training to refer to themselves as a nurse prior to this time. Maggs notes that

training for nursing and the method by which that training should be measured became of central importance to the occupation after the 1880s, culminating in the movement for State Registration of nurses. Definitions of what constituted a nurse became important as areas of dispute within the occupation, although all factions were agreed on one crucial element making up a nurse - her distinction from a doctor in gender, knowledge and practice (Maggs, 1983:14).

He states that the new system of training provided the occupation of nursing with an elevated status and engendered feelings of superiority in nurses who had undertaken formalised training. His research suggests that nursing was considered a threat to the position of the medical profession in the health system and this was one reason why there was continued opposition to the registration of nurses in

¹ What is referred to as the Nightingale system or model for nursing education is discussed at a later point in this chapter, and is further elaborated on in Chapter Four.

England. He documents the many issues surrounding the lengthy process it took for legislation to be enacted to provide for the registration of nurses in England.² However, in order to become a 'trained nurse', probationers were subjected to an examination system, which consisted of both written and oral components. Such examinations took place at various stages throughout the probationer nurse's training, as well as in order to achieve certification as a trained nurse.

Maggs identifies a notion he refers to as 'occupational imperialism'. This notion is based on the view that the nurses who trained in the new Nightingale system would then go throughout the world to train future generations of nurses. Maggs suggests that the essence of this belief was that 'progress' could be brought to underdeveloped areas, teaching the principles of self development, but not self determination. The effect of this can be seen not only in his study, but also in two studies which are briefly reviewed here to provide an overview of the influence of Nightingale on the emergence of formalised nursing in three different countries.

Susan Reverby (1987) explored the history of organised nursing in the United States of America between 1850 and 1945 in relation to caring. The essence of what she argues is reflected in the title of her work *Ordered to Care*. The civil war in the United states between 1861 and 1865 identified that there was a crucial need for reforms in nursing, and a need for an effective system for training nurses in that country. By 1873 there were three training schools established in the United States, which were patterned on the Nightingale School at St Thomas' Hospital in London. Reverby identifies that a proliferation of training schools occurred between 1890 and

² Of interest here is that the arguments for and against the registration of nurses did not extend to the registration of midwives. The Midwives Act 1902 provided for the Central Midwives Board to certificate women as midwives after a course of prescribed training at a recognised institution. State registration for nurses came about only after a protracted campaign; for details of this see Abel-Smith (1960), Witz, (1992).

1920, when hospital administrators realised that by opening a nursing school, a means of cheap labour from a workforce of women, was available to staff hospitals in which 'nursing care' was needed in return for training. Altruism and discipline were the hallmarks of the training of these nurses, and duty was the basis for caring. Strategies for reform were hampered by this ethos. Reverby identifies that numerous attempts by nurses to have caring valued, as well as to have the right to control their own activities, met with failure because of the dilemma between the duty to care for others and the refusal of society to value such caring. In addition, efforts to professionalise nursing through educational reform resulted in divisiveness between groups of nurses, particularly between those who valued work-place skills and character and those who envisaged a different future for nursing education. There are many similarities between Reverby's study and issues in nursing and nursing education in New Zealand.

Lynette Russell (1990) provides an historical account of nursing education in Australia. She traces the establishment of formalised nursing education from its early beginnings in Australia to the shift of nursing education from hospital schools of nursing in New South Wales in the 1980s. She identifies that the nursing education system in Australia developed out of Florence Nightingale's apprenticeship model, in which student nurses provided direct nursing care while undertaking their course of training. She provides details of the names and destinations of nurses who went to various Australian locations from Nightingale's training school at St Thomas Hospital in London, and how they subsequently influenced the training of nurses throughout Australia.

Her work identifies many similar concerns about the system of training nurses during the 1960s and 1970s to those identified in New Zealand at around the same time. For example, recruitment and retention problems, high attrition rates among

trainee nurses, and the general ability of the apprenticeship system of training nurses to appropriately meet the health needs of Australian society, are all factors identified in New Zealand.³ Also discussed at some length are various socio-political factors associated with efforts to change the system of nursing education from its location within the hospital system to within the tertiary education system. In particular she identifies that there was concern about adequate clinical experience, that the nurses from a system under the control of education instead of health would be detached from the realities of the hospital, and generally whether a change in the location of nursing education would be for the better. In the event, change did occur, and nursing education entered the Australian Colleges of Advanced Education, commencing at Melbourne in 1975, and followed over the next five years in other parts of Australia. However, nursing education programmes continued to exist in hospital schools, and it was not until 1983 that New South Wales state government supported nursing education taking place totally in the tertiary sector. A federal government decision in 1984 proposed that intakes into hospital based training programmes would cease in 1990, and that nursing education would be fully transferred into the tertiary sector by 1993.

Of note in Russell's study is that while she makes reference to contemporaneous changes in nursing education in the United Kingdom and the United States, she does not make any reference to the changes in nursing education that had occurred earlier in New Zealand. Yet she identifies many factors similar to those able to be identified in nursing and nursing education in New Zealand, and which led to change in New Zealand. However, this omission may reflect the lack of published literature in New Zealand concerning changes in nursing education.

³ These matters will be discussed in relation to nursing education in New Zealand in Chapter Four.

New Zealand literature

Jan Rodgers (1985) undertook an historical study which examined the persistence of the Nightingale ethos in New Zealand nursing education. The essence of her thesis is that between 1883 and 1930, nursing education was entrenched in the Nightingale model of training of nurses. This model was heavily influenced by beliefs about the role of nurses in practice, what nurses needed to know in terms of knowledge, as well as a prevailing emphasis on the moral fibre of both the student nurse and the registered nurse. In tracing the historical development of nursing and nursing education in New Zealand, Rodgers claims that this ethos influenced decisions about changes to nursing education. She argues that a decision for nursing education not to be located into universities, in particular the University of Otago in 1926, was premised on a notion that nursing was essentially a practical activity that could best be learned in an apprenticeship model. The Nightingale ethos was so pervasive, that it was incompatible with advanced education for nurses.

An earlier study by Beryl Hughes (1978a), *Nursing Education: The Collapse of the Diploma of Nursing at the University of Otago 1925-1926* provides useful information about political and social factors in New Zealand surrounding views about nursing education within universities. She asserts that a plan for a five year diploma which included two years training in hospitals, two years at the University of Otago, and one year of nursing studies collapsed because of a misunderstanding between two organisations. This misunderstanding between the University of Otago and the Department of Health was in relation to who was to pay the salaries of the two nurses who would teach the nursing component of the diploma.

Rodgers (1985) disagrees with Hughes' (1978a) contention that it was a misunderstanding about salaries that caused the demise of the Diploma of Nursing at the University of Otago, and that the Trained Nurses Association of New

Zealand was single-minded about the establishment of advanced education for nurses. Rather, Rodgers asserts

Another programme arose which while giving practical voice to the increasing need for knowledge by nurses, deferred to the desires of those who controlled nursing ... It might be said that the 'single-minded determination' of the nurse leaders, Miss Maclean and Miss Bicknell, to maintain control over nurse training was in the end the deciding factor" (Rodgers, 1985:91).

A further New Zealand study that provides insightful information into nursing in New Zealand is that undertaken by Kathryn Wilson (1995). In an historical study of the professional development of nursing in Rotorua between 1840 and 1934, she suggests the notion of 'professional closure' as an important aspect in the construction of nursing's image in the early days of nursing in New Zealand. Professional closure is defined as a means by which occupations, particularly those whose members consider these occupations as professions, limit their membership. Wilson identifies that this is done through two mechanisms. Exclusionary closure exercises power in a downward direction, and one group is subordinated to another. Usurpatory closure exercises power in an upward direction. The so-defined subordinate group, attempts to secure the perceived advantages of the so-defined 'superior' group. Wilson's account of the professional development of nursing in Rotorua illustrates these notions of professional closure in relation to the emergence of the medical profession, and nursing's counter-action which "developed and implemented rules of exclusion and strategies of usurpation to protect and enhance their emerging professional status" (Wilson, 1995:13). She identifies the influence of legislation in professional closure, that is, the enactment of the Nurses Registration Act 1901, which effectively excluded untrained women from working in hospitals. This notion of professional closure will become evident in this thesis in terms of the on-going role of legislation in the construction of the occupational identity of the nurse.

Studies related to comprehensive nursing education

An important study which provides valuable information about the way in which comprehensive nursing courses prepared practitioners in these courses was undertaken by Taylor et al (1981). In a survey which was undertaken between 1973 (when the first two comprehensive nursing courses commenced) and 1980, answers were sought to the following questions:

- 1 Do the new courses achieve their objectives?
- 2 Are criticisms of the new courses justified?
- 3 What are the most suitable forms of the courses? and
- 4 What other effects may the new training schemes have?
(Taylor et al, 1981:xvii)

The conclusions of the evaluation in relation to the first two questions reveal that there was evidence that:

- The technical institute nursing courses appear to have achieved some of the most important aims which were set for them.
- Some of the criticisms which have been made of the new courses when they were planned appear to be unjustified (Taylor et al, 1981: 171-172).

These conclusions are of particular significance to nursing education, since the results of this study formed the basis for government approval for the ongoing transfer of nursing education into the tertiary education sector. However, as chapter five will reveal, there was criticism of this study for not including the views of some groups in the study.

Following the study by Taylor et al (1981) several studies have focussed on nursing education from the perspective of graduates once they commence employment as a registered nurse. Judith Perry (1985) investigated the process of induction of nurses into the professional culture of a hospital. She utilised a critical case study approach which analysed the perceptions of five comprehensive nurses who were newly graduated, and identified a disjunction between knowledge and beliefs gained through the educational process, and those considered to be required for nursing practice. In particular, the participants in this study “became aware of contradictions and inconsistencies in their education and practice” (Perry, 1985:45). Her research identifies structural constraints present in comprehensive nursing education curricula and hospital based nursing practice. She suggests that the domination of the technical paradigm of curriculum design is inappropriate in nursing education courses in that it constrains and inhibits the professional actions and choices of new graduates once in practice as registered nurses. She argues for the design of nursing education curricula to be more socially critical in order to transform some of the existing structural constraints in health and educational organisations.

Similarly, Margaret Horsburgh (1987), as a participant observer using a natural field approach, has investigated the way in which ten graduate nurses adjusted to initial employment. She identified that although these newly graduated nurses possessed knowledge and skills which enabled them to function in their workplaces, they experienced major frustrations in the emphasis given to the technical aspects of patient care. The focus of the work environments of these nurses stressed the management of tasks which were to be achieved within a specific time frame. This conflicted with the emphasis of their nursing education course which stressed patient centred nursing care. The result of this dissonance was that the newly graduated nurses felt unable to influence the situation and came

to accept the work environment in order to fit in. An important theme which emerged from Horsburgh's research is that there seemed to be no identifiable component in the role of a staff nurse who was a new graduate which was different from any other registered nurse. There were limited opportunities for new graduates to practise nursing in the way their nursing education course had prepared them. For example the participants identified that there were management practices which prevented them from practising nursing as an autonomous member of a multidisciplinary health team for which they had been prepared, depending on context effects, such as the availability of experienced nurses as well as shift differences. While autonomous and responsible on afternoon and afternoon shifts, on morning shifts they had limited responsibility and were likely to be dependent on other nurses. It was also clearly apparent that charge nurses were a significant feature in fostering dependency of new graduate nurses because of their responsibility for systems of patient management within clinical areas.

Also apparent in Horsburgh's findings was the lack of clear differentiation between the level of practice of a new graduate staff nurse and an enrolled nurse. Horsburgh attributes this to the emphasis on task nursing, which makes the boundaries between these two types of nurses unclear.

An earlier study undertaken by Ngaire Miller (1978) focussed on professional socialisation. Her research explored the problems comprehensive graduates experience in providing nursing care in general hospitals in New Zealand. The emphasis on tasks, rules, routines and similar controls associated with a hierarchical structure with an emphasis on the rationalisation of performance are evident in the hospital environment which has a constraining effect on the new graduate who seeks to practice according to the principles of her educational course. As a result the new graduate must undergo a socialisation process to adapt to the

role of registered nurse. As she claims "... it is not until they enter as graduate nurses that they are faced with the realities of the discrepancies between the idealised professional role they learned as students and their new role within the bureaucratic structure of health agencies" (Miller, 1978:2). What is being suggested here is that there is a requirement for the new graduate to conform to a set of expectations about the role of the registered nurse which must be acquired in order for the new graduate to function as a registered nurse within an organisation. Miller found that there is conflict between professional values held by the new graduate on completing a comprehensive nursing education course and the values of bureaucratic work settings. Although the graduates retained the values from their course, they considered that they were unable to reach these 'ideals of nursing' in their present work environment. These findings are similar to Perry's (1985) study in that they highlight organisational constraints. The focal point for Miller's study is twofold: the bureaucratic organisation of the hospital, and the role development of the newly registered nurse. In terms of role development, Miller (1978:11) asserts that "professionals can be expected to experience incongruities between their professional role conception and the bureaucratic demands of the organisation". In saying this, Miller is suggesting that in order to become socialised into the hospital environment the new graduate must relinquish the values, beliefs and knowledge of her nursing education course, and obtain those values, beliefs and knowledge which are seen to be associated with other members of the nursing profession within the hospital system.

Heather Forbes (1990) explored the perceptions of nursing students of their education. She explores these from the perspective of four themes - curriculum, socialisation, professionalism and power. Her study, in which she interviewed seven students to produce critically reflexive dialogue, revealed various constraints experienced by students within their nursing education course. For example, the

environment in which the education occurs influences the students' interpretations of their social world. There were also contradictions apparent in the objectives of the nursing course and the actual practices of nurses within bureaucratic institutions such as the hospital environment. These illustrate that there is a socialisation process which has the effect of promoting acceptance of institutional constraints on nursing practice. The results of Forbes' study indicate that the dominant ideologies - or the hidden curriculum, of both institutional structures in which nursing education takes place (the polytechnic and the hospital structures), socialise the student into hierarchical structures. Hughes (1990) suggests that it seems that while nursing education aims to produce a type of practitioner which places an emphasis on nursing practice as an holistic endeavour, the influence of the work environment in which they later become employed, constrains such aspirations. Thus the dominant discourse of the nursing identity is perpetuated through a process of socialisation into a particular 'type' of nurse who is seen to be appropriate for the hospital environment.

Judith Clare (1991) has undertaken study of teaching and learning in nursing education courses, in which she investigated the experiences of tutors and students. Using critical social science to critique the social and political forces which constrain both individual and professional action, she was able to identify the ways in which these influenced choices for the participants in her study. Of importance in this study is that the participants, through the process of participating in the study, were also able to identify how political and social issues constrain choices.

A study undertaken by Jo-Ann Walton (1989) explored the nature and organisation of nursing practice in New Zealand. Walton's descriptive survey research offers valuable insights into the views of enrolled nurses and registered nurses about the nature of their practice, which is central to the way in which the occupational identity

of the nurse is viewed. In addition, there are important points made about the differences between the practice of enrolled nurses and registered nurses, as perceived by both these groups of nurses. This is part of a small published literature about differences in the practice of enrolled nurses and registered nurses. Since the issue of the place of the enrolled nurse is one which is presently being debated within nursing in New Zealand, this literature is significant to this thesis in terms of issues of professional nursing practice in relation to different categories of nurses.

Alison Dixon (1996) undertook a critical case study of five registered nurses who were previously enrolled nurses. These nurses had been practising as registered nurses for between six months and three years. Her research addresses the question of whether there is any difference in the practice of an enrolled nurse and the practice of a registered nurse. In answer to the question "what's different in your practice now from when you were an enrolled nurse?" she posed to the five participants in her study, Dixon contends that enrolled nurses control practice at the bedside. They use the direction and supervision clause which exists in the Nurses Act to do this. This means that they are able to relinquish responsibility for patient care to a registered nurse when they choose to do so. The participants also clearly illustrate the existence of a problem in terms of some of the activities undertaken by enrolled nurses in that they do things that they consider are outside the scope of their practice. This can be taken to mean that they perhaps did not appreciate the differences in the practice of the two categories of nurse until they moved from one category to another.

Dixon's study also explores the view of stakeholders in the nursing profession concerning the future of enrolled nurses in New Zealand. She notes that nursing education programmes which prepare enrolled nurses have not existed in New Zealand since 1993. She concludes that the future of enrolled nurses looks bleak as

the nursing profession positions itself for impending legislative change to the Nurses Act, and suggestions that the category of enrolled nurse should no longer exist (Ministry of Health, 1997).

Other relevant literature

Various reports have been published which are associated with the transfer of nursing education, for example Department of Health (1969), Carpenter, (1971); Department of Education, (1972); Public Service Association (1974). Others which provide information and insight into the ongoing issues in the health and education sectors clearly associated with the changes in the location and delivery of nursing education courses. A report from a workshop held in 1986, for example, provides an important overview of issues in the preparation and beginning employment of new graduates from comprehensive nursing courses, as well as recommendations for ongoing action of identified concerns (Department of Health, 1986). A perspective of the transfer of nursing education to the general system of education was published by the Department of Health in 1988. This literature is an important part of the historical discourse of nursing education in New Zealand, and will be utilised in analysing various issues as they emerge throughout this thesis.

In the historical discourse of nursing education, the New Zealand literature can be grouped into research studies and a variety of reports. Many of the latter relate to reports from workshops and forums which have sought to address some of the perceived problems associated with changes in the nursing education system. It is noteworthy that given the criticism directed at graduates of these courses since the first cohort graduated in 1975, there is little written evidence which supports or refutes such criticism. The study by Taylor et al (1981) is the only research undertaken to evaluate comprehensive nursing education courses in New Zealand since the first two courses commenced in 1973. This raises an interesting issue

about how it is known if nursing education is actually doing what it purports to do - prepare practitioners to practise nursing within the health system. Anecdotal comments made about the inadequacies of graduates from comprehensive nursing education courses suggest that there may be a variety of perceptions of nurses and nursing education in New Zealand.

The research undertaken in New Zealand by by Rodgers (1985) identifies the persistence of the Nightingale ethos of nursing as an essentially practical occupation. Studies undertaken by Miller (1978), Perry (1985), Horsburgh (1987), Forbes (1990) and Clare (1991) all indicate that there are various structural and organisational constraints which influence the way in which graduates of comprehensive nursing education courses eventually practice nursing. Given that the purpose of the transfer of nursing education was to produce a different nurse from that which had prevailed for some seventy years, that is, a nurse able to practice autonomously and function in a variety of clinical settings (Perry, 1985, Horsburgh, 1987, Forbes, 1990, Clare, 1991) the literature identifies that once new graduates enter the workforce, there is an expectation that they conform to the dominant view of what a nurse should be. This view focuses on the technical aspects of what nurses do.

It seems, therefore, that there is a discrepancy between the occupational identity constructed by nursing education and that of the clinical environment in which registered nurses eventually practise nursing, as well as societal perceptions of the nurse. This has the effect of negating, to some extent, the educational process that nursing students undertake. Thus previous studies have revealed that there are socio-political forces which act to perpetuate the dominant view of what a nurse is and what a nurse does. However, these studies represent the perceptions of students, graduates and teachers associated with comprehensive nursing education

courses. While this is crucially important information in terms of an emerging literature of nursing education in New Zealand, these studies do not fully explore and analyse relationships between knowledge and power. In particular, they do not unmask the power relations which discursively position the nurse in the discourses of medicine and gender, and perpetuate a specific view of the occupational identity of the nurse.

This thesis seeks to unravel the factors which contribute to, and perpetuate these discourses, utilising a critical approach which draws heavily on the insights of Michel Foucault, particularly in terms of knowledge and power, as well as other critical theorists. No such approach has been undertaken in studies of nursing education in New Zealand. Thus the contribution of this thesis is a different perspective to a growing body of New Zealand literature on nursing and nursing education.

CHAPTER THREE

FRAMEWORK FOR ANALYSIS

“Perception of the world is perception influenced by skill, point of view, language, and framework. The eye, after all, is not only part of the brain, it is part of tradition...” (Eisner, 1992:11)

The analysis of this thesis can best be understood as an investigation into how the occupational identity of the nurse has been, and is constructed in New Zealand through curriculum in the context of social structures. The approach used cannot be rigidly defined according to one particular methodology in the traditional sense of research discourses. In that this thesis represents a critical analysis of the construction of the nurse, it is necessary to utilise interlocking and interrelated axes. The first of these is an historical axis, which is necessarily descriptive in that it traces how the establishment of formalised nursing commenced in New Zealand, then leads to examining changes that were made to nursing education, commencing in the 1970s. These are analysed in terms of the curricula associated with different systems of nursing education, as well as the notion of knowledge and how it has affected the construction of the nurse in both these systems.

The second axis of this thesis is a critical analysis which incorporates a broad critical framework by which to investigate the construction of the occupational identity of the nurse. Insights and concepts from the works of Michel Foucault are heavily utilised to advance the argument of this thesis that nurses are discursively positioned within the discourses of medicine and gender. However, within the forces and events which have contributed to the shaping of the nurse both in the

past as well as the nurse of the present, are issues associated with knowledge and education which are explored through the work of critical theorists, in particular, Jurgen Habermas (1972), Paulo Freire (1970, 1985), and Brian Fay (1987). This chapter elaborates on these matters, particularly in terms of how each of these theorists have informed various aspects of the thesis.

While the archive of nursing and nursing education represents the data, it needs to be made clear that the methodology can in no way be defined as historical or historiographical. Instead, it is informed in this regard by the view of Foucault, for whom history is always a *history of the present*. Foucault rejects traditional narrative history and the continuities, causes and effects that historians show interest in. Rather than seeing the present as emerging unproblematically from this historical record, Foucault aims to show that rather than being where we are in the present is because there was no alternative, the processes that have led to present practices and institutions, were not inevitable. He further utilises many deeply entrenched emotional myths, which take the form of a struggle between heroes and monsters (Gutting, 1994). Thus Foucault's methodology differs from conventional historical research in that: "It signifies a different level of analysis, one which focuses not on the history of ideas, but on the conditions in which the subject ... is constituted as a possible object of knowledge" (Smart, 1985:27).

In the sense that this thesis can be considered as a history of the present as it endeavours to apply Foucault's ideas to the discursive constitution of the nurse, it is helpful to reiterate that the nursing identity is the subject of this thesis. Use of the notion of subject is used here in the Foucauldian sense, that is "the person, individual or human being ..." (Henriques et al 1984:2). According to Foucault, the meaning of any element in the world is able to be ascertained only in relation to other elements and to the whole socio-political process. Each element must

be understood as components in a structure, and within this frame of reference the human subject is de-centred and understood as constituted as the product of historically structured discursive technologies of power (McHoul and Grace, 1993). Foucault thus provides a way in which to identify the different modes by which human beings are made into subjects. Important in this is the question of subjection and the political struggles associated with identities. He claims that the fundamental philosophical question of 'being' or 'subjectivity' cannot be separated from political practice (McHoul and Grace, 1993). Underpinning the methodology in this thesis is Foucault's *power/knowledge* problematic which is used as a way of exploring how socio-political factors operate to constitute the nursing identity.

As indicated in chapter one (refer to page 5) there is no suggestion in this thesis that use of the term nursing identity should be taken to imply that there is one identity which fits all nurses. The term is used in a singular way for convenience. Indeed as Foucault's work identifies, attempts to fix identity in the sense of binding the individual to the 'truth' of an identity are problematic (Butler, 1992, Sawicki, 1994). Foucault (1982) asserts that it is this that ensnares and subjugates the individual and permits the "simultaneous individualization and totalization of modern power structures" (Foucault, 1982:216).

Critical analysis and poststructuralism

It is important to clarify at this point what is meant by use of the notion of **critical** in this thesis. The critical perspective or critical analysis which this thesis adopts is one which is not considered to be the same as *Critical theory*. Critical theory is a theoretical tradition which developed from what is referred to as the Frankfurt school, in which a specific group of German scholars writing in the 1920s investigated certain social structures, such as science, culture, social and economic

systems from a perspective which originated from Marxism.¹ The critique or emphasis of critical theory has an orientation towards the way in which values of freedom and democracy are impeded by social structures that are constructed socially. Critical theory examines and questions frameworks by which people's lives are organised in terms of sources of repression and social domination, and locates human relationships in terms of structural variables such as class and power. One of its basic tenets is that just as we make our worlds, then ultimately we can change them (McCarthy, 1978; Held, 1980; Carr & Kemmis, 1986; Foster, 1986).² The work of critical theorists mentioned at the outset of this chapter as part of the theoretical axis is included in the analysis of this thesis to explicate the intent and focus of changes to nursing curricula.³

The critical analysis used for this thesis could be described as a poststructuralist analysis, in the sense that it follows Foucault's poststructuralism, described by Edward Said (1983:201) as "a worldly poststructuralism". By this is meant a form of historical materialist analysis which enables discursive systems to be understood in relation to material pre-discursive practices in which they arise and are embedded (Olssen, 1996). The usefulness of poststructuralism is that at its simplest level it is a method of critical analysis. It is able to provide a way to focus attention on how theories are generated, their hidden assumptions and the resultant questions and issues that emerge from such analysis. Poststructuralism subverts the boundaries

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- 1 A second generation of critical theorists, with Jurgen Habermas as its leading proponent emerged during the 1950s (Fay, 1976; McCarthy, 1978; Held, 1980).
 - 2 Critical theory will be elaborated on in relation to changes apparent in nursing curricula with the introduction of undergraduate nursing degrees during the 1990s.
 - 3 A discussion of the relevance of the work of these theorists to this thesis is provided at the end of this chapter.

between disciplines and utilises an array of positions and discourses. It rejects any single “truth’ or metanarrative and thus avoids grand-theorizing, and offers a different way of considering knowledge. It is not a theory as such, but a way of critiquing philosophy and knowledge (Sarup, 1989). Poststructuralism is of particular use in this thesis for analysing the overarching themes of knowledge and power in nursing education and the shaping of the nursing identity. As Sarup (1989:4) notes, poststructuralism “... involves a critique of metaphysics, of the concepts of causality, of identity, of the subject, and of truth”. Or as Jane Flax (1990) clearly identifies, poststructuralism rejects enlightenment themes, which include particular notions of truth, a stable and coherent self, and a rationalist and teleological philosophy of history.

Foucault’s assertions in relation to critique are useful for explaining that the notions of criticism or critique do not necessarily imply negativity. He claims: “... critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, uncontested modes of thought the practice that we accept rest” (Foucault, 1981:154). While the thinking of Foucault in his many works is defined by others as within the realm of poststructuralism, it is important to note that Foucault never defined himself as a poststructuralist. Maxcy (1994) explains that in the 1960s and 1970s Foucault, as an ‘historian of ideas’, developed a branch of structuralism that centred on changes in institutional discourse and the impact of this on the lives of people over time. Foucault, however, rejected any association with the term ‘structuralist’, and as his scholarly work demonstrated antipathy to grand theory and metanarrative, this increasingly associated him with the poststructuralist agenda. In response to a question of what he “was”, Foucault (in Martin, 1988:9) said

I don't feel that it is necessary to know exactly what I am. The main interest in life and work is to be someone you were not in the beginning. If you knew when you began a book what you would say in the end, do you think you would have the courage to write it? What is true for writing ... is also true for life. The game is worthwhile insofar as we don't know what will be the end.

Foucault's resistance to being defined in any philosophical sense, however, has meant that others have done it for him.

It is also important to differentiate between the poststructuralism that has been attributed to Foucault and that which has been attributed to others such as Derrida. For Derrida (1977), the emphasis is the linguistic where he claims all is text and literature is the centre of analysis. The difference between textual analysis and Foucault's historical materialist analysis⁴ and his rejection of the priority of language is apparent when he says

I believe one's point of reference should not be the great model of language and signs but that of war and battle. The history which bears and determines us has the form of a war rather than a language: relations of power, not relations of meaning (Foucault, 1980:114).

Poststructuralism and postmodernism

A further point which requires clarification in relation to the methodology for this thesis is use of the terms 'poststructuralism' and 'postmodernism'. Maxcy (1994) identifies that postmodernism arose as a literary and artistic movement which moved to encompass a general and political critique of modernism and structuralism. Poststructuralism has been considered to have developed as a subspecies of postmodernity as well as a method of reconstructing scientific discourse. Both concepts are frequently used interchangeably. Although using the

⁴ Not all Foucauldians share this view. For a discussion on Foucault's historical materialism, see Olssen (1996).

terms synonymously, Sarup (1989:118) differentiates the two in suggesting that: "Postmodernism is in part a description of a new type of society, but also in part a new term for poststructuralism in the arts". Kicheloe and McLaren (1994:143), however, believe that identifying postmodernism with poststructuralism is misleading. While they acknowledge similarities exist between the two, they argue that

Postmodern theoretical trajectories take as their entry point a rejection of the deeply engrained assumptions of Enlightenment rationality, traditional Western epistemology, or any "secure" representation of reality that exists outside of discourse itself. Doubt is cast on the myth of the autonomous, transcendental subject, and the concept of praxis is marginalized in favor of theoretical undecidability and textual analysis of social practices.

Richardson (1994) is of the view that poststructuralism can be considered as a particular kind of postmodernist thinking (after Weedon, 1987). She suggests that poststructuralism points to the "continual cocreation of the Self and social science: they are known through each other" (Richardson, 1994:518). Thus in poststructuralism knowing the self and knowing about the subject are intertwined.

Although the term poststructuralism is used in this thesis, no distinction is made between this term and the term postmodernism. Lather (1991) notes that conflating these terms may not be popular, but it can be acceptable to use the terms synonymously. What is of importance in terms of poststructuralism and postmodernism is that they both invite exploration of new ways of knowing. This thesis does not undertake to debate any differences between them, as its purpose is a critical analysis of the construction of the nurse identity, from a perspective that has not previously been undertaken: a poststructural critique. Cleo Cherryholmes (1988:166) describes the value of poststructural criticism clearly when he says

Structural themes, narrative history, linear planning, and models of rational choice force order on things. Poststructural criticism shows this orderliness to be tentative, propositional, contingent, incomplete, and ambiguous. Themes and distinctions revealed by structural interpretations are thereby made problematic.

Discourses

The notion of discourse is crucial in this thesis, and the various discourses associated with the nursing identity will be identified and analysed throughout this thesis. Discourse is used here in the Foucauldian sense. Chris Weedon (1987:108) who draws on the work of Foucault in positioning herself as a feminist poststructuralist provides a clear account of what this sense is when she says that discourses are

... ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and the relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern. Neither the body nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which the discourse constitutes the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases.

Foucault argues that discourses develop through certain practices and knowledge which include particular rules or procedures. These aspects enable statements and claims to be made about the 'truth', which may be unrelated claims initially, but eventually come to be recognised as the 'truth'. Such truth claims force conformity to rules and procedures, because it is essentially what it is that is believed about ourselves. Discourses, therefore, construct and position by producing "regimes of truth". As Foucault asserts, they are constructed through the interplay of power and knowledge by systems of administration and classification which fix people

within their gaze (surveillance) and determine norms which in turn define what is normal and what is deviant or abnormal.

Foucault (1977) highlighted the existence of instruments of discipline which maintain the status quo. His emphasis on normalisation through processes “...concerned with the establishment of measurements, hierarchy and regulation around statistical norms” (Ball, 1990:2) are evident in the assumptions and beliefs that society makes about what a nurse is, what nursing is, and how nurses should be educated. Chapter four of this thesis discusses the construction of a nurse initially as a “docile body” through the discourses of gender and medicine in which servitude and obedience were entrenched, and examines how these discourses not only influenced the development of the initial nursing identity but continue to influence contemporary nursing education. This will be illustrated in chapters five and eight, which examine shifts in the location and emphasis of nursing education.

Important in the processes of normalisation is the examination, which Foucault (1977:184) suggests

combines the techniques of an observing hierarchy and those of a normalising judgement ... At the heart of the procedures of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected.

That the state examination which was introduced in the Nurses Registration Act 1901 still exists as a requirement for registration (or enrolment) as a nurse emphasises the disciplinary technologies that continue to shape the nursing identity. In Foucault’s work which focussed on how systems of surveillance were set up to manage, regulate and discipline others, however, he did not see knowledge in terms of power to do things. Rather his interest was in the way that knowledge is used to control others. It can be seen then, that there is an

interrelationship between the notions of subjectivity, discourses, power and knowledge. For Foucault, there is "... no knowledge without a particular discursive practice; and any discursive practice may be defined by the knowledge that it forms" (Foucault, 1972:183). The discourses within which the nurse identity has been constructed highlight in Foucault's terms, discursive formations or discursive practices. Foucault (1980:200) asserts that these are

...not purely and simply ways of producing discourse. They are embodied in technical processes, in institutions, in patterns for general behaviour, in forms for transmission and diffusion, and in pedagogical forms which at once, impose and maintain them.

He thus identifies the mutually productive and reproductive aspects of social and political institutions and discursive practices. He also emphasises three facets of discursively formed practices, which, he claims are that they are historically contingent, dynamic and conflict ridden (Flax, 1993).

In terms of discourses and their discursive practices, Foucault's interest is in charting the standardisation and uniformity of western society, where dominant institutions are crucial to the way in which the "...rationalization, organisation and homogenization of society" (Couzens Hoy, 1986:131) is constructed. Deviations from what is considered normal are not tolerated. Who defines this, and how such uniformity and standardisation occurs are of interest to Foucault, and are of importance for this thesis. This matter will be explored in relation to the nursing identity in terms of the themes of knowledge and power, and are illustrated in chapter six which examines curricula and chapter seven which is concerned with the notion of knowledge.

Power and Foucault

The notion of power is also of crucial significance in this thesis. The view of power that Foucault proposes needs elaboration at this point, since it is this view that is adopted. Foucault makes it clear that power is not vested in one person or institution when he says

One doesn't have here a power which is wholly in the hands of one person who can exercise it alone and totally over the others. It is a machine in which everyone is caught, those who exercise power as much as those over whom it is exercised... Power is no longer substantially identified with an individual who possesses it or exercises it by right ... (Foucault, 1980:156)

Foucault's interest in isolating the connections between power and knowledge underwrites his works. In describing the mechanisms of social power and knowledge, he suggests that their relationship is inextricably intertwined, and that power limits the acceptability of what is to be known. Thus power is viewed differently for Foucault. He does not see power as being relational in the sense of relations between one group (the dominant) and the other (the subordinate). This makes his view of power unlike the way power is understood in critical theory. In critical theory, power is considered in a relational way in positive or negative terms which espouses a view of power as oppositional. In a negative view of power, it is considered to reflect oppressive and exploitative effects of the relations of domination. Viewed from a positive perspective, power can be considered to reflect its creative and productive aspects in a way that can be used to harness its transformative capacity. This suggests that power has an emancipatory potential in that through a process of empowerment an oppressed group gains both enlightenment about its particular situation as well as acquiring a resolve and will to act in a unified way to become emancipated (Oluga, 1996).

For Foucault, however, as Sarup (1989:82) points out “... conceiving of power as repression, constraint or prohibition is inadequate: power ‘produces reality’; it produces domains of objects and rituals of truth”. Power is thus seen as productive since it can be through the repressive limitations of power that knowledge can be developed either in response to or in resistance to resistive elements. Power and knowledge, then, are mutually generative. As Foucault says

There is no power relation without the correlative constitution of a field of knowledge, nor at the same time any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977:27).

It was through the use of spatial metaphors that Foucault came to what he was looking for: “*the relations that are possible between power and knowledge*” (Foucault 1980:69). As he asserts

Once knowledge can be analysed in terms of region, domain, implantation, displacement, transposition, one is able to capture the process by which knowledge functions as a form of power and disseminates the effects of power (Foucault, 1980:69).

Foucault’s analytics of power

Rather than thinking of power in terms of what it is and where it comes from, Foucault’s concern is with the question of how power is exercised. Foucault insists that the juridico-discursive conception of power needs to be set aside in order to determine how power is exercised. For Foucault the ‘juridico-discursive’ notion of power is to be rejected because, he claims, it is

taken to be a right, which one is able to possess like a commodity, and which one can in consequence transfer or alienate either wholly or partially, through a legal act or through some act which establishes a right, such as takes place through cession or contract. Power is that concrete power which every individual holds, and whose partial or total cession enables political power or sovereignty to be established (Foucault, 1980:88).

In *The History of Sexuality Volume One*, Foucault (1978) proposed an “analytics” of power, which he saw as “... a definition of the specific domain formed by relations of power and ... a determination of the instruments that will make possible its analysis” (Foucault, 1978:82). He considered that such an analytics could only be constituted if it was freed completely from what he terms “juridico-discursive” representations of power. Within an analytics of power, then, Foucault is concerned with how power is exercised, and he defines the exercise of power as “... a way in which certain actions may structure the field of possible actions ... a mode of action upon the action of others ...” (Foucault 1982:222). In order to analyse power relationships, Foucault (1982:223) suggested that five points need to be established. These points are summarised as follows:

- 1 **The system of differentiations** which permit one to act upon the actions of others. Such differentiations are determined by law, traditions of status and privilege; economic differences, and so forth.

- 2 **The type of objectives** which are pursued by those who act upon the actions of others. This includes the maintenance of privileges, accumulation of profits, exercising of a function or bringing a statutory authority into operation.

- 3 **The means of bringing power relations into being.** This may be through threat of force, surveillance, rules, or economic disparities.

- 4 **Forms of institutionalization** which includes traditional or legal structures, such as the family or other hierarchically defined structures such as the State.

- 5 **The degrees of rationalization** which brings power relations as action into play, and legitimates processes for the exercise of power, depending on the situation.⁵

Although Foucault studied various institutions, such as the prison and the clinic, it is not these that are his focus, but instead “institutions from the standpoint of power relations” (Foucault, 1982:222). This, he insists, is because although power relationships may be embodied in institutions, they are not themselves power relations. He points out that “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” (Foucault, 1978:86).

The framework Foucault proposes for analysing power relations relocates power from within a view which considers power as repressive, to one in which power is productive. This perspective makes it possible to illustrate how power is exercised in relation to the construction of the nursing identity within various institutions. Power can be seen as being exercised outside the law and the State. Rather than being centralised, it operates to produce at the physical, material, physical and corporeal level of daily existence (Foucault, 1980). What can also be seen within this analytics of power is that power is strategically reversible. Power relations can only occur where there is the potential for resistance. As Foucault (1982:220) points out

A power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that “the other” (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts, and that, faced with a relationship of power, a whole field of responses, reactions, results, and possible interventions may open up.

5 Refer to Chapter five, pages 92, 98, 104, and 110 for further discussion on these points.

Thus Foucault is demonstrating that if there is no freedom to resist or to act in another way, then absolute domination or constraint by physical means is implied (MacNay, 1994). Attention therefore needs to be given to possibilities for resistance and practices of freedom. Chapter twelve will particularly address this matter.

Bio-power and governmentality

As a way of identifying certain knowledges and their attendant practices which construct and normalise society, and increasingly ordered and regulated all realms of society, Foucault (1978) proposed the notion of **bio-power**. By this he referred to the macro-social functions of power/knowledge in the investigation and regulation of populations (Papps and Olssen, 1997). In *The History of Sexuality* he asserts that “The disciplines of the body and the regulation of the population constituted the two poles around which the organization of power over life was deployed” (Foucault, 1978:139). In relation to bio-power, Foucault says the State no longer relies on force by which to regulate populations, rather it is forms of knowledge which regulates through the description, definition and delivery of forms of normality (Foucault, 1980). As the State increasingly became the paramount agent in the exercise of bio-power, new forms of political rationality were constituted (Olssen, 1997). The notion of **governmentality**, first used by Foucault in a paper published in 1979, was introduced to counter criticisms of his treatment of power. As Lois McNay (1994:85) notes

Foucault’s subsequent work on the idea of governmentality overcomes some of the limitations of the previous notion of bio-power. The idea of governmentality broadens the category of power by distinguishing more clearly between violence, domination and the type of power relations that characterize relations between individuals ... it (power) is no longer understood to operate in a unidirectional fashion through the inscription of material affects upon the body. Rather, it is conceptualized as an ‘agnostic struggle’ ... this allows Foucault to explain systems of social regulation in terms less one-dimensional than ‘an endless play of dominations’.

Foucault used the term 'governmentality' in an interchangeable way with government (Burchell et al, 1991). Governmentality is seen by Foucault (1982) as the "conduct of conduct". Two meanings can be seen in this view. First being 'conducted' in the same sense of being 'subjected', and second, a person's own conduct or behaviour. For Foucault governmentality represents a contact point between technologies of domination and technologies of the self. Technologies of domination are exercised in relation to the body in order to produce "subjected and practised bodies, docile bodies" (Foucault, 1977:138). Technologies of the self relate to practices which work to create a particular kind of identity through constructing the needs and desires of the body. Individuals act upon themselves to produce this identity which is instrumental to the ends of the State. Disciplinary technologies can illustrate how power operates by attaching nurses to certain forms of identity. Hence the notion of governmentality is usefully employed in describing the mechanisms that enable various groups and discourses to construct and regulate individuals and groups. This becomes apparent in the historical axis throughout this thesis in relation to the discursive constitution of the nurse over a seventy year period in New Zealand, which is the focus of chapter four, and in chapters five and eight in terms of a shift of emphasis on a different type of practitioner and different location for nursing education. Additionally, the notion of governmentality is implicit in the discursive practices in the construction of the nurse as a culturally safe, caring and reflective practitioner in relation to emerging discourses, explicated in chapters nine and eleven.

Foucault's 'positions'

While it cannot be said that there is any association between Foucault in the sense of a "framework" of ideas, or that any of Foucault's approaches represent a system of analysis, it must be recognised that Foucault adopted specific terminology for the way in which he approached various topics during his life. His early works were

called “archaeologies”, the works which followed on were defined as “genealogies” and his last works prior to his death in 1984, which related to the history of sexuality were termed “problematizations”. It is important to elaborate on these aspects of his work.

Mark Poster (1993) identifies three positions Foucault adopts during his work on the self. First, the period of archaeology during the 1960s, at which time Foucault critiqued the self as rationalist through a strategy of reversal. In this strategy, by pitting madness against sanity, rationalist claims were able to be challenged by interpreting the authenticity of madness as a form of decentering. The second position of genealogy which was evident in the 1970s, critiqued the subject as a centred core through shifting the focus of subject to structure. The period of ethics during the 1980s critiqued hermeneutics of the self by studying the discursive practices of self constitution. Lois McNay (1994) observes that it is in the work that Foucault did in relation to ethics that there is a reversal of his position of critiquing the Enlightenment. Foucault addressed this, however, in saying “...we must try to proceed with the analysis of ourselves as beings who are historically determined, to a certain extent, by the Enlightenment” (Foucault, 1984:43).

Sarup (1989) identifies that Foucault’s genealogical analysis is different from historical analysis in several ways. Traditional history seeks to document a point of origin; it explains events in terms of linear processes, with events inserted into systems of explanation and linear processes in which great moments and individuals are celebrated. Genealogical analysis addresses the discredited rather than the spectacular, and in doing so attempts to establish the singularity of events by focusing on “local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchize and order them in the name of some true knowledge” (Sarup, 1989:64).

According to Flynn (1994:28) Foucault insisted that

the question of power relations, which characterizes his genealogies, was what his archaeologies were really about and, subsequently, that the issue of truth and subjectivity, the explicit focus of his final works, had been his basic concern all along.

Foucault (1984:45-46) maintains that it is through practices of critique that we can undertake a “ ... historical investigation into the events that have led us to constitute ourselves as subjects of what we are doing, thinking, saying”. Through this critical ontology of ourselves three political systems are addressed. Foucault (1984:48) explains that these “ ... stem from three broad areas: relations of control over things, relations of action upon others, relations with oneself ...”. There are three axes, according to Foucault, which are identified as knowledge, power and ethics. It is these axes that he claims need to be analysed both from a perspective of specificity and interconnection in order to address the questions of: “How are we constituted as subjects of our own knowledge? How are we constituted as subjects who exercise or submit to power relations? How are we constituted as moral subjects of our own actions? (Foucault, 1984:89). In investigating these questions, Foucault is fundamentally seeking the answer to the question: “Who are we”?

Early in his life Foucault identified his objective as understanding the history of the different modes by which human beings are made into subjects. He suggests three ways this happens; first, via the human sciences, which developed after the start of the nineteenth century, second through the ‘dividing practices’ which objectify the subject and provide classifications for subject positions, for example ‘mad’, ‘normal’, and third, by human individuals who themselves have agency to turn themselves into subjects, and through resistance, to change history. Foucault

asserts that individuals identify with particular subject positions within discourses.

A concern with dividing practices is associated with Foucault's early interest in activities in which the "subject is divided from himself or divided from others" (Foucault, 1982:208). In this thesis it is argued that the nurse can be seen to have been objectified through dividing practices by being divided from others (medical practitioners) by the discourse of gender, in which the nurse was initially positioned within a discourse which emphasised womanly virtues. The discourse of medicine further divided the nurse from the medical practitioner through a differentiation of knowledge. The discourses defined the person of the nurse as different from the person of doctor. The systems of training and education in which the nurse has been prepared provides a further example of dividing practices.

Later, Foucault (1982:208) considers "the way in which a human being turns him - or herself into a subject" to be a central concern of his writing. In this respect, discourses are internalised and the subject identifies with the discourses. For the nurse, this means definition of self within the shifting relations or subject positions in the discourse. So while the occupational identity of the nurse may have been initially located within the discourses of gender and medicine, new (and perhaps competing) discourses have emerged which locate the nurse in a different subject position. Internalising the discourse redefines the nurse-self. This will become apparent in chapter eleven in relation to the discourses of caring, reflection and cultural safety.

The place of critical theorists in this thesis

According to Michael Peters et al (1996), critical theory was first used to characterise a different form of knowing. That is, it was used as a way of distinguishing this form of theory from empiricist accounts of scientific knowledge.

Critical theory was seen to be a form of knowledge anchored in reflection as well as practice. Jurgen Habermas (1971) argues that knowledge is shaped within the context of historical, social and political conditions, and that it is determined by specific interests, needs and desires. He developed the idea of *knowledge-constitutive interests*, as he believed that technical knowledge was necessary, but that other forms of knowledge were also valid and necessary for human society. He categorised three forms of knowledge-constitutive interests - the **technical**, the **practical** and the **emancipatory**. The importance of these in this thesis relates to their parallel with discourses or paradigms of knowledge and knowledge development, the **technical** with the empirico-analytic sciences, the **practical** with the historical-interpretive sciences, and the **emancipatory** with the critical social sciences (Habermas, 1987). The place of these three knowledge-constitutive interests in relation to the nurse and nursing education will be illustrated in chapter seven with regard to the interrelationship between knowledge, truth and power.

Aspects of the work of Paulo Freire (1970, 1985) in this thesis pertain to his notions of empowering and emancipatory education, and in this respect, in chapter eight, the influence of North American nurse educators concerned to create a “curriculum revolution” on nursing education in New Zealand is introduced. Brian Fay’s (1987) view of critical social science is of value to this thesis in highlighting a shift in nursing curriculum requirements to include emancipatory knowledge. It is argued in chapter nine that the emancipatory intent of the introduction of cultural safety to nursing education was neither well articulated nor understood.

Thus the work of critical theorists is utilised in this thesis to illustrate how nursing has utilised emancipatory knowledge to challenge power relationships and construct a nursing identity which differs from that constructed within the technical discourse. However, as Michael Peters (1996:12) explains

Critical theory is meant to provide a guide to action: in particular it is meant to enable agents to determine their interests, and thereby, produce enlightenment. They are therefore considered to be inherently emancipatory, since they will free agents from distorted ideological practices and forms of coercion which are at least partly self imposed. Yet it is this very conception of the humanistic, self reflective, unified individual subject that is considered problematic from the viewpoint of poststructuralism.

Peter's (1996) view illustrates the concern of this thesis to go beyond the conception of the nursing identity as a "humanistic, self-reflective, unified" entity, which implies a categorised individual, attached to an identity which "imposes a law of truth (Foucault, 1982:212). It also helps explain why the insights of Foucault are useful for critically analysing the discursive constitution of the nursing identity since this thesis is concerned with how the nurse is defined, produced, and reproduced. Use of Foucault's 'positions' and his notions of governmentality and discourse provide a means of unmasking power relations in the connections between power and knowledge, through an analysis of the totalising and individualising effects of modern power structures.

Chapter summary

In this chapter the the reader has been provided with an overview of the theoretical framework utilised for this thesis. It has emphasised the importance of applying the work of Foucault to the discursive construction of the nurse, as well as introducing the place of other critical theorists in various chapters of the thesis.

SECTION TWO

ESTABLISHING AND MAINTAINING THE NURSE

This section consists of five chapters. In Chapter four, the influence of the State on the construction of the nurse within the discourses of gender and medicine is described and analysed through both historical and critical axes. In particular this chapter explores the emergence of nursing as an occupation with a snapshot of the first seventy years of formalised nursing and nursing education in New Zealand. Chapter five continues with a focus on nursing education, but its emphasis is on a shift which disrupted the dominant view of nursing education and the nursing identity. Through historical and critical axes, this chapter highlights the micro politics surrounding the transfer of nursing education from hospital based programmes into the tertiary education sector.

There is a link between the next two chapters (six and seven) in terms of curricula and knowledge which highlight the social networks of power. Chapter six has as its focus the prescriptive requirements of nursing education curricula which illustrates the influence of the State in the discursive constitution of the nurse, as well as the way in which particular nursing education curricula emphasised the skill base of nursing and reinforced medical and gender discourses. Chapter seven focuses on knowledge and knowledge development in relation to nursing and nursing education curricula. It illustrates the privileging of particular knowledge, and specifically knowledge from the empirico-analytical paradigm, but is also concerned to explore and analyse the interrelatedness of knowledge, truth and power.

Finally, in this section, chapter eight examines the micro politics of a further shift in nursing education in relation to the commencement of undergraduate degrees in nursing. In addition, an emerging emphasis on emancipatory knowledge in the construction of the nursing identity is an important part of this chapter.

CHAPTER FOUR

CONSTRUCTING THE NURSE: A DOCILE BODY

The emergence of formalised nursing in New Zealand within the apprenticeship model of nurse training which was imported with nurses trained in the tradition of Florence Nightingale's beliefs about nurses and nursing was embedded within the discourses of gender and medicine. With the introduction of legislation to register nurses following a specified training programme of three years, the technologies of gender and medicine became dominant discourses in the shaping of the nurse and nursing, and was to prevail for almost seventy years. This chapter provides a critical analysis of how this happened, through an analysis of the micro politics of power in terms of new forms of power and domination. It illustrates in particular the role of the State in the construction of the nursing identity, initially through the adoption of a system of training nurses consistent with Nightingale's model. The influence of the State in relation to the emergence of different categories of nurses in New Zealand is also apparent, as medicine separated into specialties, where different hospitals housed different groups of patients, and nurses with specific skills areas were needed. Within this context Foucault's notions of bio-power and governmentality are central to the creation of nursing as a formalised occupation as an act of government in controlling populations.

Foucault's insights into disciplinary power and the notion of the 'docile body' are utilised in this chapter to discuss influences that shaped the nurse and nursing. In Foucault's terms this represents an analysis of the construction of the nursing identity in terms of "how power is exercised". In his work *Discipline and Punish*, Foucault (1977:136) used the term docile bodies to highlight that "(a) body is docile that may be subjected, used and transformed". The notion of docile bodies is

part of the wider issue of disciplinary power, in which the body is located in a political field. Within this political field it can be said to be subjected, in that the power relations with which it is invested render it productive but at the same time docile (Smart, 1985). Foucault contends that during the classical age the body was discovered as an object and target of power, and that it is not difficult to identify ways in which the body was "... manipulated, shaped, trained, which obeys, responds, becomes skillful and increases its forces" (Foucault, 1977:136). In *Discipline and Punish* he provides insightful examples of this, using prisons, the military and schools to make his point about disciplinary processes. Foucault's intention in emphasising the significance of the body as a site of power was to show that knowledge of the body made it possible to organise and subjugate bodies into docile and useful roles.

The establishment of formalised training for nurses within hospitals with rigid prescriptions of what was to be learned and strict rules about conduct and standards of morality can be considered within Foucault's descriptions of disciplinary practices, as a technology of domination. Immersed within the hierarchical structure of the hospitals in which training occurred, surveillance through the "gaze" of other nurses, hospital administrators, the medical profession, and most importantly, members of the public, the nurse was constructed through processes of normalisation. The formalised training system also promoted the measurement of the nurse through the notion of "examinable competence" (Chua and Clegg, 1990).

The body of the nurse within the space of hospitals was therefore part of

... a machinery of power that explores it, breaks it down, and rearranges it. A 'political anatomy', which was also a 'mechanics of power' ... defines how one may have a hold over others' bodies, not only so that they may do what one wishes, but that they may also operate as one wishes, with the techniques, the speed and efficiency that one determines. Thus discipline produces subjected and practiced bodies, 'docile bodies' (Foucault 1977:138).

In order to analyse the effect of disciplinary processes on the construction of the nursing identity, the historical axis is employed throughout this chapter to describe the way in which nurses and formalised nursing emerged in New Zealand.

Florence Nightingale and nursing

The construction of the nurse as a docile body within the discourses of gender and medicine through disciplinary practices was effected by reforms of nursing championed by Florence Nightingale. Her influence extended to New Zealand as this country was colonised during the latter part of the 19th century, as British trained nurses were imported to improve the health status of the new colony (Rodgers, 1985). Although history records that persons referred to as nurses who engaged in what might be called the activities of nursing were in existence long before Florence Nightingale (Achterberg, 1990), it is she who is considered to have had considerable influence on the way in which both hospitals and nursing changed during the 1800s. Brian Abel-Smith (1960) is careful to point out, however, that the reform of nursing should not be solely attributed to Florence Nightingale, since her training school which was founded in 1860 at St Thomas's Hospital in London was not the first to commence the training of nurses. He notes that nurses were trained from 1848 at St John's House under the supervision of clergy, and in 1856, pupil nurses learned the skills of nursing and provided cheap labour for King's College Hospital. What Florence Nightingale achieved in her approach to nursing and the training of nurses was to give nursing an element of respectability. At the basis of her beliefs about nursing was a determination that nursing should not be controlled by the church, and that there was a danger of care of the body becoming confused with care of the soul by nursing "falling into the hands of religious groups" (Abel Smith, 1960:19).

Prior to Nightingale's influence in reforming both the public image of nurses and the image of hospitals, Cecil Woodham Smith (1954:50-51) notes that hospitals in England had a reputation of being regarded as

... places of wretchedness, degradation and squalor. 'Hospital smell', the result of dirt and lack of sanitation was accepted as unavoidable and was so overpowering that persons entering the wards for the first time were seized with nausea ... The patients came from the slum tenements ... from hovels, from cellars where cholera lurked. Gin and brandy were smuggled into the wards and fearful scenes took place ... The insuperable objection was the notorious immorality of the nurses ... it was practically unknown for a respectable woman to become a nurse.

Susan Reverby (1987:22) suggests that the women who worked in hospitals were seen as "... the dregs of female society ... who drank themselves into oblivion to endure their seemingly thankless and wretched labors of cleaning, feeding, and watching over the hospital's inmates". In addition, Charles Dickens, when he wrote *Martin Chuzzlewit*, conjured up an image of a nurse - Sairey Gamp - portrayed as a gin-soaked and garrulous woman who hired herself out to private patients as a nurse and midwife. This image was so enduring in the minds of the public that Dickens felt bound to comment as an introductory note in later editions of his book. This disclaimer, which first appeared in 1868, recognised that his portrayal of nurses in his work no longer appropriately represented the image of the 'new' nurse created from the Florence Nightingale model. Dickens wrote

In all my writings, I hope I have taken every available opportunity of showing the want of sanitary improvements in the neglected dwellings of the poor. Mrs Sarah Gamp was, four and twenty years ago, a fair representation of the hired attendant of the poor in sickness. The hospitals of London were, in many respects, noble Institutions; in others, very defective. I think it is not the least among the instances of their mismanagement, that Mrs Betsy Prigg was a fair specimen of a Hospital Nurse; and that the Hospitals, with their means and funds, should have left it to private humanity and enterprise to enter on an attempt to improve that class of persons - since greatly improved through the agency of good women.¹

¹ This appears in the preface to many editions of Charles Dickens' *Martin Chuzzlewit* from 1868.

Nonetheless, this image of the nurse which was to prevail in English society, was what needed to be sanitised. Nightingale did this by aligning her direction for nursing with the values of piety, commitment, and above all else, obedience - the Nightingale ethos (Rodgers (1985).

Almost without exception throughout history, nursing has been associated with women. Although nursing has several heritages, the biological one seems to prevail. Hence perspectives on women are relevant to perspectives on nurses and the activity of nursing. Part of the folk image of the nurse is associated with woman. The nurse has been seen as a mother who was the nurturer of others, but she nurtured by nature. She may have been wise, she may have been a healer, but she was unlearned (Achterberg, 1990). Florence Nightingale exploited the nature/nurture issue, in addition to the virtues of morality, piety, and obedience. The modelling of nursing on environmental theories stressed that the nurse's role was one which created both physical and moral cleanliness (Reverby, 1987).

An emphasis on the environment and nature formed the basis of Nightingale's beliefs about nursing and the role of the nurse. For her, the essence of nursing was "... to put the patient in the best possible condition for nature to act upon him" (Nightingale, 1859/1969:133). Indeed as Mary Povey (1989) observes, the way that nursing was conceptualised by Florence Nightingale actually challenged the basis of medical men's power which was the right to determine who was a patient in need of care. However, in order for nurses to achieve credibility and respectability in patriarchal Victorian society, it was necessary to ensure that the role of the medical practitioner was not undermined. This meant that nurses always had to be in a subordinate relationship to the doctor. Moral character and obedience became paramount in the training of nurses in order to maintain this relationship,

and it was this that separated the Nightingale nurses from any other nurse of the past. As Povey (1989) observes, although this self-proclaimed subordination actually enhanced the reputation of the activity known as nursing by helping to neutralise gender aspects of independent women, it also sustained the domestic ideal.

The nurse became discursively positioned within the gendered discourse of what she *was*. To be a good nurse also meant being a good woman, and a good woman was an obedient one. Character rather than skills was the ethos of Nightingale's views of the nurse, and this was repeatedly instilled in the minds of those women who wanted to become nurses. As she wrote in 1881 in a letter to a group of trainees at St Thomas's Hospital

To be a good nurse one must be a good woman; here we shall all agree ...

What makes a good woman is the better or higher or holier nature; quietness - gentleness - patience - endurance - forbearance ... with her patients - her fellow workers - her superiors - her equals. We need above all to remember that we came to learn, to be taught. Hence we came to obey.

... as a mark of contempt for a woman is it not said, she can't obey? She will have her own way? As a mark of respect - she always knows how to obey? how to give up her own way? You are here to be trained for Nurses - attendants on the wants of the sick - helpers, in carrying out Doctors' orders (Cited in Diamond, 1980).

There can be little doubt that Florence Nightingale was able to successfully alter the public image of nurses and nursing. Yet there were two facets to Nightingale's image. On the one hand there was the image of self-sacrifice and nurturer of the sick, self-effacing, kind and gentle. And on the other hand, courageous, resolute and efficient; able to deal with the horrors of war, as she did in the Crimea, and determined to reform hospitals and nursing (Povey, 1989). These two images converged in Nightingale and opened up a space in English society, eager for

answers to the terrors of infectious diseases such the cholera epidemic in the mid nineteenth century, and looking towards medicine to provide these answers. By emphasising discipline in nurses as well as cleanliness and hygiene as key elements in the health of patients in hospitals, Nightingale was able to carve out an area of expertise for the new type of nurse. The changes made space in hospitals, but also corresponded with other social changes occurring in society at that time associated with a strong work ethic, and a greater regimentation of life in general (Vicinus, 1985).

Although Nightingale's insistence that being a good nurse also meant being a good woman created the opportunity for nursing to become respectable, it had the effect of positioning nurses and nursing in a place which was one of subordination to the (male) medical profession. Nurses were women, and the consequence of this was that they did not establish an intellectual space within the medical world, because as attendants of the sick in hospitals they were seen as helping the doctor in carrying out his orders (Gamarnikow, 1978). In addition, as Versluysen (1980) notes, women were excluded from the recognised practice of 'physick' by the Royal College of Physicians and other male 'empirics' guilds. This differentiated men from women in a division of labour based on a belief that the knowledge of the medical profession was superior and beyond the ability of women. In terms of patient care, women (nurses) were considered to have intrinsic expressive maternal and caring qualities. Men (medical practitioners) were seen as the scientific head when it came to patient care. The formulation of nursing established by Florence Nightingale was to have far reaching effects in the establishment of nursing as an occupation. As with America and Australia, to which Nightingale's nurses were exported, it was only a matter of time before the newly colonised country of New Zealand would be influenced by Nightingale's model of nursing and nursing education.

Early nursing in New Zealand: 'every woman a nurse'

During the settlement of New Zealand as a colony from around 1840, the sick, or those women settlers who needed care and/or assistance during childbirth were cared for at home. The title 'nurse' was given to many women who had medical knowledge or skill. In one sense, as Rodgers (1985:19) identifies: "Every woman was a nurse". Furthermore, since nursing was not defined as an occupation, anyone was able to describe themselves a nurse and call the activities they undertook in caring for the sick, nursing.

State hospitals were eventually established in the provinces during the early 1840s (Dow, 1991). Initially these hospitals were opened in Auckland, Wellington, Wanganui and New Plymouth with government funding to provide medical treatment to Maori as well as for indigent settlers (Tennant, 1989). However, it was only the severely ill, poor, or destitute who resorted to hospitals, as they were not particularly pleasant places (Rodgers, 1985). Towards the end of the nineteenth century, as a result of the gold rushes of the 1860s and 1870s and an increase in the population, by 1882 New Zealand had some 37 hospitals (Dow, 1991). A 'Master' and a 'Matron' had responsibility for the management of early New Zealand hospitals. Any 'nursing' care needed was provided by unqualified staff - women - from the so called 'domestic classes'. There was an expectation that patients who were convalescing would assist staff in the care of sicker, less able patients (Burgess, 1984; Rodgers, 1985).

But the real indictment of these early hospitals was that many individuals would have been treated better in their own homes than in a hospital (Rodgers, 1985). This was recognised by officials within the Department of Health. In 1882 Dr Grabham, a hospital administrator with a background of experience at St Thomas's

Hospital in London (the location of Florence Nightingale's nursing school) was appointed as Inspector of Hospitals (Dow, 1991). He was keen to improve the state of hospital services in New Zealand, and being aware of the work of Florence Nightingale, was of the view that nurses who had been trained in her nursing system, could be effective in such an improvement. As Stewart and Austin (1962:264) note: "British trained nurses were sent for".

As a result of Dr Grabham's request for this new type of reformed nurse, Nightingale trained nurses first came to New Zealand in the late 1870s and during the 1880s (Rodgers, 1985). Their impact in hospitals did not go unnoticed. In his 1884 report to Parliament Dr Grabham observed

A very excellent system of nursing is in full operation at the Wellington and Auckland hospitals where well-educated ladies may be seen serving their apprenticeships with other probationers. Trained nurses from these two schools will gradually become distributed in various parts of the colony. The example so set might with advantage be followed by others of the larger hospitals whose present nursing arrangements are not in accordance by any means with modern ideas (Department of Health, 1951:3).

Exactly what it was that this new nurse was or did that was different, however, is not clear. But it seems it was in their character or demeanour that the difference was apparent, as by 1887, Dr Duncan MacGregor, appointed as Inspector-General of Hospitals in New Zealand, noted his satisfaction with the nursing staff at Wellington Hospital. In his annual report to Parliament he commented that they were "... well trained, intelligent and ladylike, evidently being drawn from a class very much superior to the old-fashioned hospital nurse of former times" (AJHR, 1887:23).

It is clear that the new nurse was able to be differentiated from the untrained 'caretaker'. As Jan Rodgers (1985) points out, not only were they punctual,

trustworthy, clean and orderly, they had considerable endurance in the performance of 'degrading' duties which included skills in dressing wounds and the care of helpless patients and meeting their personal needs. In essence this new type of nurse, was, according to Una Maclean (1974:63)

A complete contrast to that of her casual, amateurish predecessor. In place of a sluttish, amiable female of dubious morals, the Nightingale model appeared as a fresh young girl, pure in body and mind. She was 'sober, steadfast and demure', and represented an ideal of piety and personal service to which any daughter of a respectable middle-class family might aspire. With impeccable morals she combined skilled powers of observation, technical competence and a reliability which sprang from a habit of implicit obedience.

Not everyone, however, shared Dr MacGregor's view about these new nurses. At Christchurch Hospital in 1895 the 'old-fashioned' nurses resisted the views of the new approach to nursing and made life difficult for the staff who had responsibility for administering the hospital - a resident surgeon and the matron. Christchurch Hospital did not have trained nurses as early as the hospitals in Auckland and Wellington. Although the first trained nurse was appointed to the position of matron at Christchurch Hospital in 1881, the staff who were responsible for providing nursing care were untrained women. By 1891, more trained nurses were employed to be in charge of the wards, and probationer nurses were also taken on for training as nurses (Somers Cocks, 1950). Sybilla Maude - who was later to develop the Nurses Maude district nursing service in Christchurch - became the matron in 1893, but resigned in 1896, not long after a Commission of Inquiry into the management of Christchurch Hospital.

The concerns expressed by the public of Christchurch around this time, and which were part of the inquiry into the way in which Christchurch Hospital was managed, related to the new system of training nurses. It was believed that the nurses trained in this new system would be inadequate to minister to the sick and the suffering.

In part this was because the older nurses believed that their years as 'good and faithful servants' were devalued, but also because the nurses who were trained in the new system were considered to be from a group of refined and educated young women, unsuited for the rigours of nursing the sick (Wilson, 1995).

Sybilla Maude's difficulties with the older nurses not trained in the new ways may have had more to do with her view of nurses which perpetuated the Nightingale ethos of obedience. In 1908 she wrote in relation to "hospital etiquette"

To hear a nurse answer 'Yes, Sir', is surely more professional than 'yes, Doctor,' and to stand to receive orders, if it be only from the sister of the ward is equally important; of course there must be precedence in all grades of the profession, from the visiting staff to the newest probationer. Another point of etiquette too often violated is the questioning of doctors' orders, after he has left the patient. Whatever a nurse may think, her duty is to obey without expression of opinion, as after all the patient is in the doctor's charge, the nurse being required simply to carry out his instructions faithfully (Maude, 1908:36).

It is apparent that the older nurses were used to different conditions and were more than likely from a different background to the new type of nurse promoted by the Nightingale ethos. As Somers Cocks (1950:33) notes

The training of the nurses which had begun two years before Nurse Maude's arrival was haphazard and irregular, and the discipline was lax. The quarters in which they lived were quite inadequate and appalling ... with conditions such as they were, it could not be expected that many self-respecting girls would come to take up their training.

There can be little doubt, however, that MacGregor's impression of the value of the 'new nurse' helped with the later establishment of state registration for nurses in New Zealand. In fact he was given the credit for it (Dock, 1912, Rodgers, 1985).

The regulation of nurses in New Zealand

The introduction of legislation for the registration and training of nurses was not something supported by Florence Nightingale. She vigorously opposed the control of nursing being taken away from nurses, and maintained that what it was that made a nurse was not something that could be determined through this process (Abel-Smith, 1960; Maggs, 1983). The establishment of the nurse as a legal identity in New Zealand through the enactment of legislation which led to a national system of training and state registration as a nurse represents a crucial shift in the way nurses and the occupation of nursing were perceived. But this also had the effect of discursively positioning the nurse in terms of what she *did* as well as what she *was*. Now what each nurse was able to do was assessed throughout her training and her competence examined formally at the end of the training programme before being called a nurse. Through linking the training of nurses with what nurses were able to do, and associating this with medicine, authority was derived through the discourse of medicine.

What can be seen here, is an example of the contested dynamics of knowledge production, that is, how power and knowledge come together, according to Foucault (1980) *is* historically specific. In addition, Foucault's notion of governmentality is associated with the emergence of a type of professional 'subject', which produces certain types of professional expertise. Nikolas Rose (1988:185) identifies Foucault's emphasis on the importance of discourses which make possible "new practices of regulation" so that "the management of the human factor in the institutions of modern social life could now operate in terms of a norm of truth; that is to say, in terms of a knowledge of subjectivity which had the authority of science". The nurse as a legal entity was positioned as a type of expert and produced as a subject of her professional discourses (Johnson, 1993).

Nurses first became a legal entity in New Zealand with the enactment of the Nurses Registration Act 1901. Although it has been suggested that credit for the initiation and eventual achievement of the Nurses Registration Act 1901 was claimed by Dr Duncan MacGregor, the Inspector of Hospitals in the Department of Health (Dock, 1912; Rodgers, 1985), the driving force behind the regulation of nurses, followed by the regulation of midwives, was Grace Neill, who was Assistant Inspector of Hospitals in the Department of Health between 1895 and 1906 (Neill, 1961). Grace Neill proposed to the Government that the training of nurses should be standardised. This included a standard curriculum, State Examinations which all student nurses had to pass, and the introduction of a Register of nurses.

The proposal to introduce legislation did not go unchallenged by those in the health system at that time. Mary Lambie (1952:6) notes that opposition was from

the various Matrons and training schools feeling they would lose their identity and be moulded into a common pattern to the detriment of individual development. However, the Government ... realized the forcefulness of her representations, and in 1901 the first Registration Act for Nurses in the world was passed which inaugurated a course of three years' training with the State examination and the Register.

In 1899 Grace Neill attended the International Council of Women's conference in London, where she, along with with one of the protagonists for the registration of nurses in Britain (Mrs Bedford-Fenwick), was one of the principal speakers of the nursing section which was debating the issue of state registration for nurses.² The essence of the Hospital Nurses Bill, which was presented to Parliament in July 1901, was the basis of Grace Neill's address given to the International Council of Women in 1899 (Rodgers, 1985).

² The International Council of Nurses dates its existence from this assembly (International Council of Nurses, 1986).

The paper she presented to this forum was entitled *The Professional Training and Status of Nurses* (Neill, 1961). Since the Nurses Registration Act subsequently specified what the training requirements would be for nurses, it is interesting to note Grace Neill's views on what training in preparation for registration as a nurse should comprise. She believed that

The educational curriculum of hospitals should embrace a three year training. The first years chiefly on ward work with the rudiments of anatomy and physiology. This teaching to be undertaken by Sisters or third year nurses under the Matron's supervision. The second year's course to include cooking, rudiments of chemistry, food values etc. Third year to include the training and teaching of juniors, and a foreign language (Neill, 1961:43).

Although there was some debate during the passage of the Bill through Parliament about the size of hospitals in which training could take place, it seems that there was little opposition to the notion of either a formalised system of training or registration. Some members of parliament were opposed to the requirements in the Bill for a training school to be located within a hospital with a specific number of beds (Rodgers, 1985). This particular clause was deleted, and the Nurses Registration Act 1901 provided for the training of nurses at any public hospital, as long as there was "... a course of at least twelve lectures ... delivered in that hospital in each of the three years' residence" (Nurses Registration Act 1901). Registration could, however, be achieved in more than one way. Section 4 (1) of the Nurses Registration Act 1901 provided for registration for those nurses who had already undertaken training in a hospital in New Zealand. This section states

Every person, who on the coming into operation of this Act holds a certificate of three consecutive year's training as a nurse in a hospital, and proves to the satisfaction of the Registrar that during her training she received systematic instruction in theoretical and practical nursing from a medical officer and matron, is entitled on payment of a fee of ten shillings, and on application to the Registrar on or before the thirtieth day of June, one thousand nine hundred and two ...

Presumably, this provision was to ensure that such individuals would not be disadvantaged by the introduction of new legislation. But it may also have been to ensure that distinctions could be made between the untrained 'nurse' and the trained nurse. There were lists of nurses - trained or untrained compiled for the benefit of medical practitioners. During the 1890s, the Auckland branch of the New Zealand Medical Association had such a list of some 17 nurses, only 10 of whom were trained (Wilson, 1995).

Those individuals who did not have such a certificate, however, could attain registration as a nurse if they had had four consecutive years training in a hospital as a nurse, and pass an examination in theoretical and practical nursing which was set by appointed examiners (Nurses Registration Act, 1901). The first recorded information about such examiners appears in a report to Parliament in 1908 - "Report on Nurses Registration, Midwives and Private Hospitals Act" - which notes that the Registrar of Nurses, who was now Dr Valentine, had appointed a Board of Examiners to "study the question of nurse training and examination". This Board, which comprised 19 doctors and 10 nurses was to advise and co-operate with the Registrar on these matters (AJHR, H-22, 1908:5, p7).

The medical profession was afforded considerable influence by the State in relation to the governance of nurses and nursing, both in terms of what nurses were to learn during a three year period of training and be examined on as well as in relation to the conduct of nurses. Rodgers (1985) identifies that the enactment of the Nurses Registration Act 1901 was pivotal to the strengthening the position of women in terms of the occupation of nursing as well as establishing controls for the direction of nursing education. But it was not necessarily nurses who controlled nurses and nursing. There was a significant amount of control vested in the medical profession

through the enactment of this statute. The Registrar was a medical practitioner³ with considerable statutory responsibilities. The Nurses Registration Act 1901, Section 2 states “Registrar” means the Inspector-General of Hospitals in New Zealand. Even though there was a nurse - Grace Neill - in a senior position in the Department of Health, she was not afforded the responsibility of Registrar of Nurses. The Registrar had the statutory authority to remove the name of any registered nurse from the register of nurses if convicted of any indictable offence or, if proved to the satisfaction of the Registrar and any Magistrate to have been found guilty of “grave misconduct” (Nurses Registration Act 1901). Acquiring the ‘status’ of being a registered nurse, then, was accompanied by an expectation to conform to a particular standard of conduct. What that was, however, was not clearly defined.

There was also control of nurses by medical practitioners. The number of medical practitioners appointed by the Registrar of Nurses to the Board of Examiners illustrates the influence of medicine in the education of nurses, and helps to explain the effect of medical discourses on nurses and nursing. This is a pattern in the regulation of nursing that continues for some time. It was not until the enactment of the Nurses and Midwives Registration Act 1925⁴ that the Nurses and Midwives Board was established as the regulating body for nursing, taking the control of nurses and nursing (as well as midwives and midwifery) out of the hands of one person - the Registrar, and to some extent, the medical profession. When the new Act was enacted in 1926, the office of Registrar became the responsibility

³ This was initially Dr Duncan MacGregor, a medical practitioner who was Inspector- General of Hospitals between 1886-1907. He was influential in this position in the establishment of hospitals in the New Zealand.

⁴ This essentially combined two previous pieces of legislation - the Nurses Registration Act 1901, and the Midwives Act 1904.

of a nurse, Miss Jessie Bicknell, who was also the first Director of Nursing in the Department of Health (Lambie, 1952). The Nurses and Midwives Board continued until the enactment of the Nurses Act 1971, which established the Nursing Council of New Zealand. Chapter ten will further discuss the governance of nurses through regulatory processes of the State which acted through technologies of domination to 'normalise' the nurse as a docile body.

The emphasis on the historical construction of the nurse in this chapter is not intended to suggest that power is to be viewed as a unidirectional and monolithic force. Rather, its intention is to illustrate the complexity of power/knowledge relationships and authority in relation to a professional discourse which discursively produced the nursing identity. This exemplifies what Foucault (1978:100-101) refers to as

a multiplicity of discursive elements that can come into play in various strategies ... Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy.

Thus the discursive elements of the discourses of medicine and gender operated to create the nursing identity, but also function to undermine its stability.

Different nurse identities

While the establishment of formalised training for nurses commenced as a result of the enactment of the Nurses Registration Act 1901, this legislation was only applicable to nurses. During Grace Neill's term of office within the Department of Health, she was also instrumental in the development and subsequent enactment of the Midwives Act 1904, which regulated the education and practice of midwives.

The regulation and education of nurses and midwives were eventually to become intertwined during the first half of the twentieth century. The 1925 Nurses and Midwives Registration Act, which combined the Nurses Registration Act 1901 and the Midwives Act 1904, made provision for a further category of nurse - a maternity nurse. This new registration category could be achieved following an eighteen month programme of training, and was seen to be necessary because of difficulties identified in the maternity services area. Mary Lambie (1952:16) asserts that obstetrical nursing practice had

fallen under criticism as it was felt that the period of training was insufficient (six months for a registered nurse and one year for an unregistered woman) and further that many registered nurses trained as midwives had no intention of practising and so there was a shortage of well qualified women. A Royal Commission of Enquiry had been held in 1924 concerning New Zealand's high mortality rate, particularly from puerperal septicaemia, and among its recommendations were far reaching reforms in regard to the training and practice of obstetric nurses.

It should be noted that these nurses were in fact legally entitled maternity nurses according to the Nurses and Midwives Registration Act 1925 rather than obstetric nurses as Lambie suggests.⁵ Their specific function was to assist medical practitioners in caring for women during labour and childbirth. Unlike registered midwives they were not permitted to take responsibility for the care of women during childbirth unless a medical practitioner was in charge, nor were they able to be licensed to conduct a maternity hospital. They were not designed to have any independent function, and in essence their limited function cast them in a supporting role to medical practitioners. Their creation as a legal entity may say more about the need for medical practitioners to have assistants, since midwives were able to practice autonomously.

⁵ The term obstetric nurse did not exist until the enactment of the Nurses Act 1977. Those nurses with registration as maternity nurses became obstetric nurses at this time. This term remains current.

The Nurses and Midwives Registration Act 1925 also made provision for women who were untrained but who had been practising as maternity nurses to attain registration within one year of the Act being passed, and some 658 women obtained registration as maternity nurses in this way (Maclean, 1932) ⁶. Worthy of note here is that these women had not undertaken any formal training. It seems their experience was considered appropriate enough for them to obtain registration as a nurse, albeit that they were required to function under supervision from medical practitioners. Concern about the health of women and babies was a significant issue in New Zealand society during the first half of the twentieth century, which led to the establishment of other categories of nurses. Earlier than maternity nurses was the “plunket nurse”.

In Dunedin on 14 May 1907, the Plunket Society was born when Dr Truby King, Superintendent of Seacliff Mental Hospital addressed a group of women in the Dunedin Town Hall about his vision to improve the care and nutrition of children, particularly those who were considered “waifs and strays boarded in foster homes” (Parry, 1982:16). One of the members of staff at Seacliff was a young woman - Joanna McKinnon. Although she was not trained as a nurse, as Parry (1982:16) notes she “... had shown herself to be capable and receptive, a quick learner”. Truby King recognised this ability, and taught her all he knew about baby care and making up “humanised milk”, and set her up as his missionary in the city of Dunedin, where, under his watchful eye, she championed the cause of better infant nourishment, and trained others in the ways of achieving this according to Truby King’s beliefs. Hence the Plunket nurse emerged initially from a perceived need in society to perform a particular function - a pattern that continued as medicine began

⁶ For an analysis of midwifery education in New Zealand and the intertwining of nursing and midwifery roles, see Papps and Olssen (1997).

to branch into various specialities and needed nurses to support their various 'treatments'.

Later in 1907, Truby King set his cottage up at Karitane - near Dunedin - as a hospital for sick children, since children under the age of two were not permitted to be admitted into general hospitals. This venture was the beginning of a bigger hospital later established in Anderson's Bay, Dunedin, which became known as The Karitane Home for Babies. For over 70 years this was the training centre for Plunket Nurses and later for the training of Karitane Nurses (Parry, 1982). But the creation of the Plunket nurse caused some controversy among nurses registered under the Nurses Registration Act 1901, who believed that the introduction of this 'untrained' nurse might downgrade the nursing profession. Of particular concern was that the first two Plunket nurses had not received any general training as nurses. As a result of a deputation from Dunedin Hospital and the local Nurse's Association, it was agreed that nobody would be able to undertake training as a Plunket Nurse unless she was a registered nurse (Parry, 1982). Thus the "plunket nurse" became this category of nurse once registration as a nurse had been achieved and on completion of a special training programme run by the Plunket Society. In doing this nurses were able to effect control over who could be called a nurse, which illustrates the notion of professional closure, an issue which will be explored in Chapter ten.

While the early developing colony of New Zealand had a need for care and assistance during labour and childbirth, and the welfare of infants and children in addition to medical care for various injuries and diseases, mental illness became an increasing concern, with the first recorded case of insanity in 1841 (Ernst, 1991). Anyone who was considered as mentally ill was treated as a criminal. Special premises for the mentally ill were established in 1844, one attached to the Auckland

Hospital and another to Wellington Jail where they were known as pauper lunatic asylums (Ernst, 1991). In 1853 a special building to contain the mentally deranged, funded through public subscription, was opened in the grounds of the Auckland Colonial Hospital, and in 1854 the first purpose built lunatic asylum was opened in Karori, Wellington (Department of Health, 1972).

During the 1860s, Oakley and Sunnyside Asylums were opened in Auckland and Christchurch respectively, along with asylums at Dunedin and Nelson. A further asylum was established in Hokitika in 1872. The only private lunatic asylum - Ashburn Hall - was established in Dunedin in 1882. Although the Lunatics Ordinance of 1846 aimed to provide safe custody for the care of persons of unsound mind (Ernst, 1991), it was not until the enactment of the Lunatics Act of 1868 that New Zealand had any mental health legislation (Department of Health, 1972).

The asylums were administered by lay administrators and a struggle began to transfer the control of these institutions from these lay personnel to the medical profession. In 1880 the creation of an Inspectorate of Asylums went some way towards establishing medical control over these institutions. Such control by the medical profession, according to Ernst (1991), was deemed (by that particular group) to be the only way of ensuring that the care provided with these institutions was adequate, and that a programme of 'moral management' was required to cure those people within them suffering from some sort of mental illness. But as Ernst (1991) comments, this 'moral management' was essentially custodial care and strictly authoritarian in nature. The attendants in lunatic asylums were, in the early days at least, exclusively men (Department of Health, 1972). Despite Dr Duncan MacGregor's work with Grace Neill in the construction of a new nurse identity through a formalised training system and the eventual enactment of the Nurses Registration Act 1901, he was unable to give the same attention to nurses in the

mental health area. In his role within the Asylums Inspectorate, Dr MacGregor had considerable authority in the management of asylums and power to dismiss staff. But as Tennant (1989) points out, he had minimal powers as Inspector of Hospitals, because the Asylums were independent in the employment of staff. In this respect, the State was not the paramount agent in the exercise of bio-power in relation to asylums, but that was soon to change in relation to these.

Although by 1890 some of the asylums had appointed trained matrons and commenced a form of on-the-job training for attendants of the patients, psychiatric hospitals developed separately within the hospital system in New Zealand (Department of Health, 1972). Formal training for nurses in the psychiatric area did not begin until 1905. The first hospital Final Examination for what were known as Mental Deficiency Nurses was prescribed and conducted by the Division of Mental Hygiene within the Department of Health in 1907. This qualification gave individuals the remuneration and status of a trained nurse. But they were not registered under the Nurses Registration Act 1901 in the same way that the nurses from general hospitals were. It was not until the enactment of the Nurses and Midwives Amendment Act 1944, that the training programmes for psychiatric nurses came under the control of the Nurses and Midwives Board in the same way that training programmes for general nurses had been since 1925. Thus just as psychiatric hospitals emerged separately from general hospitals in New Zealand, so too did the psychiatric nurse. This different heritage may be the reason for differences - real or perceived - between the general nurse who seemed to be mainly women and were more influenced by gender discourses, and psychiatric nurses who were predominantly men.

In Foucauldian terms, and in particular through Foucault's (1978) notion of bio-power, it can be seen how the State exercised its macro-social functions of

power/knowledge in relation to the regulation and investigation of various populations through the establishment of hospitals which segregated some groups from others, and was able to rely on forms of knowledge to regulate through describing, defining and delivering forms of normality (Foucault, 1980). The nurse was instrumental in this activity, but at the same time was herself regulated through description and definition, and normalised into a docile body through technologies of domination explained through Foucault's (1979) notion of governmentality.

The enrolled nurse

As the State increased its primary role of government and produced various subject positions, further categories of nurses were created. Enrolled nurses emerged from a category of health worker, first referred to as registered nursing aids following the completion of a two year nursing aid training programme established in 1939. It was thought that this training programme would "... be of value to the girl who could not pass the examination for a registered nurse ..." (Lambie, 1952:25). It is apparent that this training programme was also seen to be a way of addressing staff shortages in hospitals and sanatoria which housed patients recuperating from chronic illness such as tuberculosis (Lambie, 1952).

The period of training was reduced to eighteen months in 1949 through legislative amendment, and continued until an amendment to the Nurses and Midwives Act 1945 (The Nurses and Midwives Amendment Act 1965) created a new category for the registered nursing aid - the registered community nurse. An eighteen month course of training was undertaken in a hospital school of nursing, and it was expected that in relation to the role of registered nurses, following the prescribed period of training, these nurses "were able to perform specific tasks relating to patient care that require considerably less use of judgement" (Department of Health, 1969:64). It needs to be noted that it was at this time that a second level nurse was

created in New Zealand. Although the category of registered nursing aid was created in 1939, individuals in this category did not have the legal status of nurse. They have also been inaccurately referred to as “registered nurse aids” (Burgess, 1984; Brownie, 1993; Dixon, 1996) but they were in fact registered nursing aids.⁷

The enactment of the Nurses Act 1977 resulted in a further change to this nurse, who now became an ‘enrolled nurse’, with the length of training reduced to one year rather than eighteen months (Nurses Act 1977). This new category reinforced further the notions of the ‘first level nurse’ (the registered nurse) and the “second level nurse”, (the enrolled nurse). Although this clear distinction between levels of practice followed international trends in nursing and embedded in the 1983 constitution of the International Council of Nurses (International Council of Nurses, 1986) it was to create tensions between and among nurses. This tension was exacerbated in 1983, when an amendment to the Nurses Act required enrolled nurses to practice under the direction and supervision of a registered nurse or medical practitioner. Chapter ten of this thesis will discuss this issue further.

By 1969 there were 62 hospital schools of nursing which offered 139 basic nursing programmes. Within three year nursing programmes training was provided to prepare general and obstetric nurses, male nurses, (who undertook a general nursing programme, but not obstetrics as their female counterparts did), psychiatric and psychopaedic nurses. Eighteen month programmes prepared community nurses as well as maternity nurses. These categories of nurses emerged essentially from the need for medicine to have nurses with specialised knowledge and skills to work within various institutions throughout New Zealand - segregated because of their

⁷ This point is belaboured somewhat here because it points to the ability of the Nurses and Midwives Registration Board to govern a group of health workers who were not nurses or midwives through regulation. In chapter ten this matter will be raised in relation to the proliferation of caregivers in the health system who are essentially unregulated.

specialised nature. They were, in essence, trained to meet the needs of patients in these segregated institutions. For all these categories of nurses, nursing education programmes which had prescriptive requirements in Nurses Regulations were controlled by the Nurses and Midwives Board. As Chapter five will illustrate, these programmes were heavily influenced by medicine's philosophy towards health care.

The students within these prolific training programmes for nurses were employees of the particular hospital board in which each of the training schools was located. Each hospital board had a particular structure which constituted a structure of triumvirate management. This meant that there was a Chief Executive Officer with responsibility for the administrative aspects of a hospital board, a medical superintendent-in-chief, responsible for the medical services, and a chief nurse responsible for the nursing services. The nursing role at this level was an iteration of the role that the matron had in the earlier days of hospitals in New Zealand. Each separate hospital emulated this triumvirate management system, with a hospital administrator, a medical superintendent and a principal nurse. For nursing there was a monolithic hierarchy, which consisted of the chief nurse at the apex, a multitude of ranks of registered nurses and at the base, the essence of the nursing workforce - the students.

Nurses knew their place, discursively positioned as they were within this hierarchical structure, with its rules and regulations, its traditions, uniforms and other badges of rank which reinforced the hierarchy. Through a national system of training nurses which had its origins in the Florence Nightingale apprenticeship model, but which was standardised as a result of the enactment of the Nurses Registration Act 1901, the nurse identity was shaped into a docile body for the New Zealand health system. As Jan Rodgers (1985) observes, the nurse was

considered to occupy a central position in hospitals. That nurses were able to carry out increasingly complex tasks, acquired essentially on the job under the normalising gaze of others, and deemed to be competent through a national examination, created a dependency on the nurse and nursing services.

The location of the nurse within hospitals, structured according to the Panopticon system which Foucault (1977) adopted to describe the architecture of normalising institutions such as prisons, the army, and schools, controlled the nurse. Enclosed and ranked within this structure, the activities of the nurse were controlled by routines and rituals. This exemplifies Foucault's (1977) notion of technologies of domination in which the nursing identity can be seen to be constructed by others. The body of the nurse was defined and controlled through this technology of power and organised into a useful, practical and docile role. But all was not well. It was becoming increasingly apparent from a variety of reviews and reports that the system for educating nurses no longer met the needs of the health service, nor the needs of nursing students (Department of Health, 1988). Although the nurse was discursively positioned within the discourses of medicine and gender, as Foucault (1978:101-102) points out

Discourses are tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy; they can on the contrary, circulate without changing their form from one strategy to another, opposing strategy.

There was to be a challenge to the gender and medical discourses within which the nurse had been constructed for some seventy years, which is the focus of the next chapter. In summary, this chapter, through the utilisation of the historical axis of the theoretical framework has provided a way of looking back in order to attempt what Foucault (1988:145) urges we do to understand "what we are today".

CHAPTER FIVE

RELOCATING THE NURSE

The way that individuals were prepared for registration as nurses in New Zealand took a different direction when two new nursing education courses commenced at Christchurch and Wellington Polytechnics on 1 March 1973. A total of 78 students enrolled in these two courses (Taylor et al 1981). They were designed to prepare students for a different type of registration; a comprehensive registration which would enable individuals registered from these programmes to practise as nurses in medical, surgical, psychiatric, psychopaedic, maternal/child health and community health service areas (Department of Health, 1988). Following the establishment of these two courses, nursing education was incrementally transferred from hospital board schools of nursing into schools of nursing in polytechnics between 1973 and 1986. The number of comprehensive nursing courses in New Zealand remains at fifteen in 1997.

It may seem that between 1973 and 1997, nursing education has simply been relocated from one place to another. But it has not been a matter of simple progression; controversy and conflict have been significant features. This chapter discusses how this change occurred. It utilises the historical axis of the framework for this thesis to explore social and political issues associated with the transfer of nursing education into the tertiary education system. Additionally, through utilising Foucault's 'analytics of power', it provides a perspective on how power is exercised in the construction of the nursing identity. This is not done through focusing on particular institutions, but rather the approach is through the way "... in which certain actions may structure the field of other possible actions" (Foucault, 1982:222). As Foucault notes "the analysis of power relations within a society

cannot be reduced to a study of a series of institutions ... (p)ower relations are rooted in the system of social networks” (Foucault, 1982:224). The focus of this chapter, therefore, is how a change in nursing education disrupted the dominant view of the nurse, prevalent for some seventy years in formalised nursing education in New Zealand. The location of power relations within various social networks as nursing championed this change, and the inherent struggles are also explicated in this chapter.

New lamps for old?

According to a report published in 1974 by the Board of Health - “*An Improved System of Nursing Services in New Zealand*”, there had been four major investigations into nursing in New Zealand, and that for each of these investigations, a report was published.¹ All these reports recommended some sort of change to nursing education. Prior to the publication of these New Zealand reports, however, two reports with implications for the future of nursing education in New Zealand had been published in the United States. One report recommended the relocation of nursing education programmes from hospitals into university settings (Brown, 1948), and one recommended that nurses should be prepared to the same degree and in the same way as other health professionals (WHO, 1966). These two reports which highlight the influence of American ideas on New Zealand nursing education were key documents used by nurses to argue for changes to the system of nursing education (Christensen, 1989).

A report published in 1969 by the Department of Health ² identified that there had

¹ These four reports are those of Reid, 1974; Department of Health, 1969; Carpenter, 1971; Department of Education, 1972.

² This report is *A Review of Hospital and Related Services in New Zealand*. It highlights issues and concerns about nursing education and the provision of nursing services.

been dissatisfaction expressed over many years in New Zealand with the methods of preparing nurses for practice and identified that it was timely to look to new ways of nursing education. This report also recommended that there should be three basic nursing education programmes, and it can be seen that there is an emphasis not only on the location of nursing education programmes, but also a shift in the views of what nurses needed to be able to do. The recommendations were for

(1) a university-based programme to educate a nurse, defined by the International Council of Nurses as “that person who has completed a programme of basic nursing education and is qualified and authorised in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick”;

(2) a diploma programme, similar to the New Zealand three year general course, but offered within the system of general education, and including as in the above programme a high percentage of clinical instruction in hospitals and other health agencies, designed to prepare “nursing personnel able to provide generalized patient care of a simple nature requiring both technical and interpersonal skills”.

(3) a shorter programme, similar to New Zealand’s community nurse programme with a high percentage of time spent in clinical areas designed to prepare “nursing personnel able to perform specified tasks related to patient care that require considerably less use of judgment” (Department of Health, 1969:64).

These proposals for nursing education programmes specified here are important, as they appear to show an intended direction for differences in levels of nurses, prepared through different programmes, which follows an international trend in nursing at that time. The wording of the recommendations is almost identical to those proposed by the World Health Organisation (WHO) Expert Committee on Nursing Report of 1966. Of note, however, is that although the Department of Health’s 1969 report clearly identified that there was expressed dissatisfaction with the way that nurses were prepared for practice in New Zealand, and made recommendations for the future of nursing education, it seems to have been largely

ignored. As Shadbolt (1983) observed, it did not receive any comment in *Kai Tiaki* during 1969-70.³

This was not the first suggestion to be made about changes to nursing education programmes by an influential organisation. In 1964 the Nurses and Midwives Board, with a statutory responsibility under Section 8(a) of the Nurses and Midwives Act 1945 for determining “courses of training and instruction to be undergone by candidates for examination” approved a proposal for nursing education that represented “... a major change in the attitude, philosophy and practice of nursing’ (Nurses and Midwives Board, 1964:2-3). This proposal, developed by the curriculum planning committee of the Nurses and Midwives Board, aimed to establish three main streams for nursing education - a degree programme, a general 3-year programme and a community nurse programme by 1970.

In the event this did not happen. For reasons which are difficult to determine, none of the recommendations from any of these reports seemed to have any influence on changing the direction of nursing education in New Zealand. It was not until after the publication of the *Carpenter Report* in 1971 that there was any shift from the existing hospital based nursing education programmes. The enlistment of the services of Dr Helen Carpenter, Director of the School of Nursing at the University of Toronto, Canada, and World Health Organisation consultant to undertake a comprehensive review of nursing education in New Zealand was essentially to find solutions to problems associated with nursing education in New Zealand that had

3 *Kai Tiaki* was the journal of the New Zealand Nurses Association (in 1995 it was renamed *Kai Tiaki: New Zealand Nursing Journal*.) Reference to lack of comment about the Department of Health Report has significance, because *Kai Tiaki* was the journal of the New Zealand Nurses Association - the organisation which was the national ‘voice’ at that time for nurses, in terms of both professional and industrial matters.

been identified in previous task forces and committees. It is probably no coincidence that issues identified in previous reports were reflected in the terms of reference for the review. These were

- (1) To study pertinent information with regard to the system of education for nurses at all levels, and to consider this system in relation to the systems of education for the other members of the health team.
- (2) To study pertinent information and to secure the opinion of authorities concerning:
 - (a) social change in New Zealand and the influence of this on recruitment, education and employment within the health services;
 - (b) trends and developments in the health field;
 - (c) trends and developments in education.
- (3) To make recommendations to Government with regard to the system of nursing education in the light of the findings (Carpenter, 1971:8-9).

The *Carpenter Report* was clearly the catalyst for eventual shift in the location of the nursing education system in New Zealand. Although Helen Carpenter (1971) made many recommendations about nursing education in New Zealand, the most significant in her report was one which recommended

That a nursing programme leading to an (undergraduate) diploma or certificate be established in a college for the preparation of health services personnel established in an appropriate educational setting; this programme to be developed in co-operation with selected hospitals and other health agencies in the vicinity of the college, and that when the above programme has been successfully established, it be developed in regional colleges of health science in co-operation with hospitals and other agencies within the region; and that as the above programmes are established on a regional basis, the existing hospitals be phased out (Carpenter, 1971:5).

The "1.6 Committee"

In July 1971, the Minister of Education established a committee which was referred to as the "1.6 committee" - named this because of the particular number of the recommendation in the Carpenter Report. The task of this committee was to

... study the proposal for development of colleges of health sciences for the preparation of nurses and other categories of personnel needed for the health services; and that this committee make recommendations to the Government concerning the most suitable educational setting for the development of these colleges (Carpenter, 1971:3).

The composition of this committee is worthy of describing here in the light of its eventual recommendations. It had representatives from what could be seen to be key stakeholders in the health and education areas, as well as consumer representation. But additionally, from a socio-political perspective, it can be said that there was what might be called influential representation from areas with nothing to do with nursing or nursing education. It is hard to imagine a similar committee composition in the event of a proposal to review medical education. Perhaps the agenda of the Minister of Education, however, was simply to ensure the support and consensus of these various groups in reaching a decision about the task it was asked to perform. In the event a consensus was not reached anyway among the various membership of this committee, which is not surprising, perhaps, given the the size of the committee. It had sixteen members; representatives of the Departments of Health and Education, University Vice Chancellors' Committee, Technical Institutes Association, New Zealand Nurses Association, New Zealand Student Nurses Association, National Council of Women, Medical Association of New Zealand, and the Clinical Dean of the Otago University Medical School. There seemed to be a predominance of officials with representation from the Department of Health (3 members) and the Department of Education (3 members)

and the committee was chaired by an Assistant Director of Education from the Department of Education (Department of Education, 1972:1). Given the role of the State Foucault (1979) makes apparent in his notion of governmentality, however, it is hardly surprising that there would be such representation on such a committee.

The terms of reference for the 1.6 Committee were that it was to report to the Government on three issues

- (i) the possibility of development of Colleges of Health Sciences for the preparation of nurses;
- (ii) the possible utilisation of existing tertiary institutions for education in preparation for the health services;
- (iii) the financial implications of any proposed change in the transfer of responsibility from the Department of Health to the Department of Education for training in preparation for health services (Department of Education, 1972:2).

The 1.6 Committee met on nine occasions between October 1971 and August 1972. In addressing their task, the committee sought submissions, and received a total of sixteen submissions from groups and individuals (Department of Education, 1972). As a result of its deliberations, this committee proposed, and succeeded in convincing the government of the day, that nursing education would be most appropriately placed in the general system of education, more particularly, within the technical institute or polytechnic system. Predictably, perhaps, technical institutes were the choice of location rather than the university system in a college of health science. The earlier *Review of Hospital and Related Services in New Zealand* (1969) had indicated that many nurse leaders in New Zealand believed that nurses should be prepared in the general system of education, and that the technical institute system was the most suitable place for this to occur. It was also suggested in this particular report that a pilot scheme should be established to determine costs

and quality of such a programme and measure these against existing hospital based programmes. The emphasis therefore does not seem to have been on the value of a different way of preparing nurses, and how this might benefit health consumers, but on economic considerations.

Systems of differentiations

The choice of technical institutes as the most suitable place for the preparation of registered nurses is worthy of comment at this point. The influence of Helen Carpenter in this regard is apparent, since she was from Canada, a country in which nursing education programmes began to be transferred from hospital based programmes to community colleges in the early 1970s. However, since 1919, Canada has also had nursing education programmes in the university sector, which offer an undergraduate Bachelor of Science in Nursing degree (French, 1992).

As discussed in chapter two, in New Zealand in the 1920s, nurses had debated the need for university preparation for nurses, and a diploma programme had been established at the University of Otago. This subsequently collapsed, ostensibly because of difficulties in funding (Hughes, 1978a). Rodgers's (1985) view, however, is that the Nightingale ethos of training was "too strong to allow for university based education for nurses in training" (Rodgers, 1985:102). Whether this ethos still prevailed in the nurses among the membership of the 1.6 Committee is not able to be determined. The belief perpetuated by nurse "leaders" that nursing education was best located within the technical institute system may have been a compromise at that time, simply to relocate nursing education from the hospital based system. However, the effect of this was to create a system of differentiation. This can be seen to have positioned nursing education in a situation which, as Foucault (1982:223) points out, emphasises "differentiations determined by the law or by traditions of status and privilege; economic differences ... shifts in the

processes of production, linguistic or cultural differences, differences in know-how and competence, and so forth". The opportunity to locate nursing education within the university system, it seems, was not considered. The nurse was not seen to be a university-educated subject.

Following the recommendations of the 1.6 committee, the government agreed to the establishment of two pilot programmes for comprehensive nursing courses to commence in 1973 in two polytechnics, despite the misgivings of many health professionals and others. The location of nursing education outside the hospital system was seen to be questionable. Resistance came from some health professionals, including nurses and medical practitioners, and from employers - in particular the Hospital Boards' Association (Kinross, 1984). As Yvonne Shadbolt (1983:9) comments, in relation to the proposed relocation of nursing education

Hospital Boards, although admitting some reform was desirable, were quick to defend their school of nursing and were opposed to any change that would remove students from the workforce. Individual nurses were quick to defend what had shaped them and expressed anger and hostility at what appeared to be criticism directed at them personally and professionally. Despite the official line of the Medical Association, very few individual doctors expressed support. The majority endorsed the status quo, and many expressed concern at the prospect of 'over-educated' nurses.

It is interesting to note the similarity here with the arguments against the introduction of a national system of nurse training proposed prior to the enactment of the Nurses Registration Act 1901. Reference to 'over-educated nurses' is a comment that was frequently made at the beginning of this century around the time that attempts were being made to implement a formalised nursing education system, and when there was debate about the registration of nurses. As Megan-Jane Johnstone (1994) identifies, the medical profession resisted the registration of nurses in the United Kingdom because there was no need for women to become educated and undermine the role of the medical practitioner (see also Maggs, 1983).

The 'over-education' of nurses is a recurring theme in nursing education, and emerges again in relation to the introduction of undergraduate degrees in nursing, which is discussed in chapter eight of this thesis.

As indicated earlier there was not consensus agreement by the 1.6 Committee on the final recommendations made about the new location for nursing education. Two of its members produced minority reports appended to the final report of the 1.6 Committee which was published in September 1972 (Department of Education, 1972). One member was the representative of the Medical Association of New Zealand - Mr G Wynne-Jones; the other was the representative of the Hospital Boards' Association of New Zealand - Mr A G Wicks. Their opposition to the location of nursing education in polytechnics is one of many differing views held in relation to the final recommendations of the 1.6 Committee.⁴

The question might then be asked, what was so influential about the *Carpenter Report* that initiated the transfer of nursing education into the tertiary sector? One factor could have been the influence from an 'outside' consultant who could identify the place of New Zealand nursing education in the context of initiatives and changes taking place in other countries. Almost certainly, differing educational ideologies were influential in terms of the way curricula were being developed in general education, both in New Zealand and in other countries. Previous reports had identified that change was needed, and as noted by the Department of Health (1988:4) "A widespread feeling for a considerable period was that the system of educating nurses was no longer suited to the needs of the health service or of nursing students". A further factor that may have contributed to the acceptance of the change to nursing education was that the New Zealand Nurses Association in

⁴ The views of these two members of the "1.6" committee are located in the final report of this committee as minority reports (Department of Education, 1972).

1972 established a national campaign which was referred to as "Operation Nurse Education". Nurses around New Zealand lobbied their members of parliament to support the recommendations of the *Carpenter Report* (Burgess, 1984).

Although what is highlighted here is the complexity of micro-politics, it is worth considering that changes may not have been implemented solely because of any agreement that there were major issues of concern, particularly by nurses, about the location and nature of nursing education. While there may have been a view that there was a need to have a system of education separate from the domination of the hospital system or there may have been recognition that there was different knowledge available to nurses through another form of educational programme, these factors might have had little to do with the eventual changes which relocated nursing education programmes. There are both economic and political reasons which should not be overlooked. For example, it has been identified in chapter three that in New Zealand in 1969, there were 62 hospital schools of nursing which offered 139 basic nursing programmes. Of these, 31 offered three year general nursing programmes leading to registration as a nurse and maternity nurse, ten schools had a three year programme for male nurses. Psychiatric or psychopaedic nurses were prepared in twelve schools of nursing; 46 schools had 18 month programmes for community nurses, and 18 month programmes for the preparation of maternity nurses were provided in 19 schools of nursing (Department of Health, 1969). As Kinross (1984:196) observes "(c)learly, such a plethora of nursing programmes was both expensive and unnecessarily complex for a country providing health services for approximately three million people".

Prue Hyman (1985) notes the influence of social, economic, and interest group considerations in the transfer of nursing education. She maintains the key issues able to be identified as controversial were concerned about the practical and

financial aspects of staffing hospitals with a reduced student workforce as well as a risk of over-educated nurses in the sense that education would be beyond the scope of what was needed in nursing care. The concern in this regard was seen to be associated with the new courses having the effect of raising the expectations of nurses to have a different role, with a resulting unwillingness on their part to undertake standard tasks seen to be an essential part of the provision of nursing care. Overlooked in this seems to be a failure to identify that nursing care was provided by an unqualified nursing workforce for many years. Nursing students actually provided the majority of nursing care, albeit under the supervision of another more senior student nurse who in turn was under the supervision of a staff nurse or the "ward sister". Perhaps the concern was actually a thinly disguised protest that nurses graduating from these courses may want to undertake the activities of nursing in a different way, which, as later discussed, did happen to some extent.

Acceptance of comprehensive nursing education courses

Further courses commenced in the two years following the establishment of courses at Christchurch and Wellington - Nelson in 1974 and Auckland in 1975. Approval was given for these courses to be continued on an indefinite basis in 1976 rather than on a year-by-year basis, and a strategy was developed for the expansion of comprehensive nursing courses. Two further comprehensive nursing courses were established at Southland and Waikato in 1978, however, no commitment was given for the establishment of new courses beyond 1979 (Department of Health, 1988). The establishment of these courses seemed to have taken place, however, without any significant long term planning or policy on the part of the Government.

New courses were approved on the basis that reviews and evaluations of both the graduates and the courses showed favourable comparisons, and in some areas

better features in terms of costs, attrition rates of students, and pass rates in the registering examinations (Department of Health 1988). The new system of nursing education, therefore seemed to be addressing all the concerns that had been identified in the numerous reports on nursing education prior to the introduction of the new courses. Policy did eventuate, and strategy for the staged introduction of further courses resulted, which meant that proper planning could take place for staffing and appropriate buildings within the polytechnic system.

The introduction of these new courses created some problems in terms of the existing legislation which regulates nursing and nursing education. There was no provision for such courses in legislation. This meant they had to be constituted under the provisions of 'experimental programmes'. As already identified, the first two comprehensive courses were established as 'experimental programmes' under the Nurses Act 1971. According to the provisions of this Act, the newly established Nursing Council of New Zealand was required to consider the new "scheme" and "...with the approval of the Minister, by resolution adopt the scheme for such period as may be specified in the resolution ..." (Nurses Act 1971, Section 36(1)). However, the first two courses were given retrospective approval - they commenced in March 1973, but approval from the Nursing Council of New Zealand was not given until May 1973 (Nursing Council of New Zealand, 1974). The part played by the Nursing Council at the time of the establishment of the first two comprehensive nursing courses seems to have been minimal, which is noteworthy, given its statutory role in nursing education. Each course subsequently established had to have the approval of the Nursing Council and the Minister of Health. Even though the responsibility for the funding had shifted from Vote: Health to Vote: Education, the Minister of Health carried the ultimate responsibility for approval of new courses under the experimental section of the Nurses Act on the recommendation of the Nursing Council of New Zealand. In

fact this provision remains. Even though the Nurses Act 1977 and its amendments in 1983 and 1990 has brought about several changes to nursing and midwifery education, the Minister of Health retains the responsibility for approval of experimental programmes in nursing and midwifery. This is undoubtedly because the Nurses Act 1977 specifies that this should be the case, but it highlights the antiquity of the Act given that a shift has occurred in the location of nursing education, and funding sources have shifted. Although it emphasises the role of the State in governmentality, it raises an interesting issue that the Minister of Health rather than the Minister of Education has responsibility for nursing education programmes. Plans to introduce new legislation for nurses and midwives, which will be discussed in chapter ten, may address this anomaly.

There was, however, a desire for the continuation of, and verbalised opposition to, anything other than the apprenticeship system of training nurses which had prevailed in New Zealand for so long. This highlights two important issues. First, it demonstrates the influence of groups and individuals other than nurses in terms of how power is exercised in relation to nursing education. And second, it exemplifies some of the attitudes towards the way in which the role of the nurses and the activity of nursing is perceived. Some of the resistance to change came from groups with vested interests, such as employers of nurses for whom student nurses provided the bulk of their labour force. But resistance also emanated from nurses themselves, despite the change being championed by the New Zealand Nurses Association, the political 'voice' for nurses at that time. It is not difficult to imagine why a changed system of nursing education was in some ways controversial. It encouraged nurses to think - and to think differently about nursing. Meleis (1985:37-8) points to the heart of the issue; reluctance to admit that nursing is a thinking activity, when she comments

Nursing education has a long history of squelching curiosity and replacing it with conformity and a non-questioning attitude. Nursing education prepared nurses to think of themselves as the handmaidens of physicians, the executors of doctors'⁵ orders, and the implementers of hospital policy. It has managed to socialise students into roles that are not congruent with scholarship and discovery. Any independent thinking or critical attitude was the antithesis of what was expected of a nurse. Because nursing education was based more on apprenticeship training and experience than on ideas, knowledge and learning, the nurse graduated only to find herself ... far more dependent on the medical and hospital systems than on self-reliance and problem solving.

By the beginning of the 1980s four polytechnics offered comprehensive nursing courses. The first four courses, initially established under the experimental section of the Nurses Act 1971 had their experimental status lifted with the enactment of the Nurses Act 1977. During the establishment of these courses, hospital boards, who had responsibility for nursing programmes within hospital schools of nursing, kept these schools open. The one exception to this was in Nelson, where the Nelson Hospital Board closed its school of nursing once the Nelson Polytechnic commenced a comprehensive nursing course in 1974. There was later to be an issue about the recruitment of graduates to one hospital under the jurisdiction of the Nelson Hospital Board. Braemar Hospital, a psychopaedic hospital, held an inquiry into staffing levels, suggesting the new nursing courses failed to produce graduates for employment in the psychopaedic area. Attempts were made to reintroduce special hospital based programmes which were specifically designed to prepare nurses to work in the area of psychopaedic nursing (Report of the working party on the psychopaedic nursing staff situation at Braemar Hospital, 1982).⁶

⁶ The term 'psychopaedic' as used in New Zealand, refers to the intellectually disabled.

For a number of years in other locations in New Zealand, however, there was a dual system of preparing nurses for registration. This was able to occur because there was a reluctance on the part of hospital boards to relinquish their schools of nursing or possibly to alter their staffing to a qualified nursing workforce. Most of the nursing service, as identified earlier, was provided by a student nurse workforce, and to close a school of nursing meant rethinking and reconfiguring the nursing workforce for each hospital board. That, however, was not the only reason for the continuation of hospital schools of nursing. There remained a general unease about the change in nursing education. Despite the agreement and apparent commitment by the Government that change was necessary in nursing education, resistance from several quarters towards the new way of educating nurses was apparent. At the Hospital Boards Conference of 1982, the chairman of the North Canterbury Hospital Board made it clear that there was little support for the closure of the Christchurch Hospital School of Nursing (Grigg, 1982). It was also suggested that the two systems should continue since it was asserted that not all potential nurses needed academic training (Grigg, 1982). The basis for this assertion, however, is unknown.

In addition, at the Annual Conference of the New Zealand Nurses Association in 1981, George Gair, who was the Minister of Health left nurses in no doubt that there would be no pressure from the government on Hospital Boards to close their schools of nursing (Gair, 1981). So despite the establishment of comprehensive nursing courses within fifteen polytechnics by 1989, (refer to Appendix 1), there were still several hospital board schools of nursing which continued to provide programmes. One of these was the Auckland Hospital Board, which continued to run its hospital programme - the last students graduating in 1990 - despite the location of three separate polytechnic nursing courses within the Auckland area.

The major thrust for change in nursing education came from the New Zealand Nurses Association, which consistently argued for a date for the completion of the transfer of nursing education into the tertiary education sector, as well as from nurse educators. But this was not necessarily the view of employers, (hospital boards), who appeared to prefer the status quo in terms of nursing education. It could be argued that this might have related more to perceptions about the role of the nurse in the employment environment of a hospital. Grigg's (1982) concern appears to be associated with the relationship of the nurse to the medical practitioner. In raising the question of whether nurses are being trained appropriately for the role they are to play now as well as in the future, he claims

I have often heard statements like 'we must raise the status of the nurse' and 'we are not going to be the doctor's handmaiden', but in my opinion, we must never forget that the doctor must ultimately accept clinical responsibility for the patient, and therefore must inevitably be looked on as the leader of the patient care team in the hospital or in the community. The nurse must assist him and at times guide him in carrying out the procedures needed to treat the patient (Grigg, 1982:3).

Evaluation of the new courses

The preparation of nurses for registration in the apprentice system, as well as having an emphasis on what the nurse *was*, also had an emphasis on being trained to *do* rather than educated to *know*. The shift from this system into the mainstream education system intended to change this. It was expected that the move would not only position nursing as an autonomous profession, but it would also have the effect of producing graduates who would be independent and autonomous practitioners with a clear nursing orientation, capable of caring for patients in a variety of clinical settings (Kinross, 1984; Perry, 1985). However, as will be seen later, there were many barriers to the realisation of this outcome. While it may have been the desired outcome for nurses wishing to advance the professional status of

nursing - a matter which will be explored in chapter ten - the Department of Education was, perhaps more significantly, concerned to know how well the new courses prepared graduates to function once they were registered and entered the nursing workforce. As the comprehensive nursing courses were established on an experimental basis, there was a requirement for them to be formally and systematically evaluated. The Research and Planning Unit (later to become the Research and Statistics Division) of the Department of Education was assigned this task in the latter part of 1972. The final report - *An Evaluation of Nursing Courses in Technical Institutes* was eventually published in 1981 (Taylor et al, 1981). The main conclusions of this evaluation are important, since they emphasise that many of the criticisms of the new courses and their graduates were unfounded, and they are reproduced here in detail. They were stated as

- Entrants to technical institute courses were more likely to register as nurses, and to register in the minimum time, than were entrants to hospital three-year programmes.
- Graduates of technical institute courses were more likely to remain in the nursing workforce after registration than were graduates of hospital nursing programmes.
- Graduates of technical institute courses were able to function equally well in the various areas for which their comprehensive registration qualified them. They also appeared to be well suited for their work in the community health nursing and in more specialised areas of nursing, and were particularly strong in terms of the breadth and depth of their theoretical knowledge.
- Students did not feel they were given too much responsibility during training, and most felt theory and practice were well related in their courses.
- In terms of practical performance, technical institute graduates were not seen to be inferior to hospital graduates, except perhaps when they first started work on hospital wards.
- There was no large drop-out rate of recently registered graduates to suggest that the technical institute courses failed to detect those who were unsuitable for nursing early in training, as hospital training is purported to do.

- Students generally appeared satisfied with the technical institutes as locations for the courses.
- Although technical institute graduates spread through many hospital boards, a large proportion remained in the areas in which they trained, and there were very few in some boards. The question of whether centrally-located technical institute courses will lead to shortages of nurses in small hospitals will only be answerable when more courses have been set up (Taylor et al, 1981:171-173).

These last two statements are worthy of comment in the light of particular criticisms made by two members of the 1.6 Committee in their minority reports. Wynne-Jones (1972) asserted that technical institutes would be inappropriate learning environments for the new courses because “petty discipline” which was a characteristic of these institutions would be a significant disadvantage to nursing students. He believed that the establishment of nursing colleges would be more appropriate locations for the new courses (Department of Education, 1972). Wicks (1972), the representative of the Hospital Board’s Association of New Zealand, argued that the closing of smaller schools of nursing would result in staff shortages and eventually lead to the closure of county hospitals. In general terms, however, from these stated conclusions of the evaluation of the new comprehensive nursing courses, they appear to address previously identified concerns about attrition rates in hospital based nursing programmes, and that the courses prepared registered nurses appropriately for practice in all areas.

It is important to note here who participated in this evaluation. Taylor et al (1981) point out that the clinical performance of graduates was assessed both by graduates and their supervisors (registered nurses in clinical practice areas). Almost 60% of graduates in the evaluation survey had been working with a particular supervisor

for six months or more. It was concluded that in the majority of cases the supervisors would have been familiar with the capabilities of the graduate they were supervising. Hyman (1985) notes that there is some significance in the choice of respondents to the survey, since the perceptions of those working with new graduates and those who were not may have differed. However, there was some criticism of the evaluation survey, most notably from the chairman of the North Canterbury Hospital Board (Grigg, 1982) who claimed that hospital boards should have had input into the evaluation and that it should not have been conducted solely by the Department of Education. The graduates who participated in the evaluation survey identified some undesirable aspects, however, in particular as Taylor et al (1981:173) identify, the two most significant aspects were

- difficulties in the transition from their courses to their first jobs. This appeared to happen mainly when graduates were entering busy hospital wards which were organised on task-assignment rather than patient centred systems.
- (during the time of their nursing course) they did not have enough sustained contact with individual patients or involvement with the ongoing activities of the hospital or agencies in which they did their clinical practice.

Forms of institutionalisation

The identified difficulty in entering the workplace with large numbers of patients whose nursing care was organised on a task-assignment system is a significant issue which warrants further discussion at this point. As identified in chapter four, nursing developed a hierarchical system of organising the nursing activities in each area in terms of a clear division of labour. This was seen to be necessary when the majority of nursing care was carried out by nursing students, under the supervision of a more senior student nurse, who was in turn supervised by a more senior nurse, and so on. Nursing care was divided into ritualised and routinised tasks. The most senior nurse undertook the most complicated tasks, for example in a surgical ward

of a hospital, this person would change any wound dressings of patients and undertake the “drug round”, usually with a registered nurse (or ‘staff nurse’). The most junior student nurse would undertake what was considered to be tasks of a more menial nature, such as distributing bedpans to whichever patients were unable for whatever reason to get out of bed to use a toilet, making beds, cleaning the sluice room. One of these activities - doing the ‘bed-baths’ or ‘sponges’ as they were known - however, probably meant that the most junior student nurses were providing care to the sickest patients. The registered nurses - or staff nurses - provided little direct patient care. They were the experts in the technical aspects of nursing which involved such complex activities as looking after intravenous infusions, removing sutures and the administration of medications, generally supervising less qualified staff, and in some situations, accompanying the medical staff as they undertook daily patient rounds. ⁷

Nursing students in the new comprehensive nursing courses, however, did not learn the skills of nursing care according to this division of labour. As will be discussed in chapter six, these courses all adopted a new approach to patient care; an “holistic” approach, the fundamental tenet of which was the provision of ‘total patient care’ rather than to divide care activities into tasks. Clinical experiences for students were organised on this basis. Nurse tutors from the polytechnic courses accompanied students to (most) clinical areas and supervised them closely as they provided nursing care to assigned patients. This meant that one person did everything that a particular patient may need. So despite the way in which the nursing care delivery system of a particular ward may have been organised, the students learned about caring for patients in a supernumary capacity to the nursing staff allocation for each ward or area in which they gained clinical experience. In

⁷ This is the personal experience of the writer who completed a general and obstetric nursing programme at a large metropolitan hospital during the mid-sixties.

one sense students were in a rather protected environment. Throughout New Zealand, however, hospitals organised care delivery systems on different bases, so what may have been the experience of some students from one geographical area may not have been the experience of students from another geographical location.

Although it is important to recognise that new graduates learned the skills of nursing in a different structure from the task oriented system of nursing care predominant in New Zealand hospital settings during the 1970s in particular, there may have been some unsophisticated reinforcement of their perceived inferiority as graduates, such as in the comment made by the head of one nursing course, who said

It is only fair to state that we know that the graduates from these programmes may not be as clinically competent at first, or as task oriented as her hospital counterpart. She functions best where nursing care is patient- centred, whether in hospital or community. Given six months which will include an orientation programme to the community or hospital where she is working, she should be functioning in a broader and more effective way (Seymour, 1978:7).

Of significance here is the suggestion that clinical competence is not gained until at least six months' further clinical experience is obtained after registration. Registration, however, confers particular responsibilities on a registered nurse. The notion of clinical competence is also an interesting term, given that according to one of the requirements of the Nurses Regulations (1979, 1986), no student can be considered as an applicant for registration as a comprehensive nurse until the course has been completed. If this is taken to mean that students need to be able to demonstrate that they are safe to practice nursing, then it raises an important question about what clinical competence actually means. The view of clinical competence being associated with time, inadvertently perhaps, reinforces the view held by the Public Service Association, which in 1974 published a report on

nursing education. In this report it emphasised that there should be an intern year for new graduates to bring them 'up to speed' in terms of clinical competence. The notion of an internship for graduates of comprehensive nursing courses is also a view held by other individuals and groups in relation to the education of nurses, and, as will be discussed chapter eight, was the topic of a national conference held during 1995 (refer also to Appendix Five).

The transition from student to staff nurse is a significant issue in terms of the expectations of employer, as difficulties experienced by some students seem to have been generalised to all graduates of all comprehensive nursing courses. What is overlooked in this matter, and is a tension between nursing education courses and employers of nurses, is the expectation from some employers that new graduates from these courses will be able to function from the first day of their employment at the same level as any experienced nurse. A further ongoing issue is the clearly identified need for new graduates to have an adequate orientation programme to the work environment (Department of Health, 1986). It could be said that it is an unrealistic expectation that familiarity with the routines and rituals of any work environment can be the same for individuals who have not been socialised into that environment as students of the hospital based programmes were throughout a three year programme, the clinical requirements for which were essentially in the same hospital. Students within the hospital based programmes were frequently the most senior person on a ward during an afternoon or a night shift, with registered nurses working as supervisors, and upon whom students could call between the 'rounds' that were undertaken by this nurse during the course of an afternoon or night shift, if needed.

With the change to a qualified nursing workforce which took place with the transfer of nursing education, registered nurses now undertook this responsibility. This,

of course, means that students did not have an opportunity to be 'in charge' as a student. The appropriateness of this practice seems questionable anyway, given that one of the reasons for high attrition rates of student nurses identified by Carpenter (1971) and earlier reports on education was that students often had too much responsibility at an early stage of their training.

It may well be that the issue of competence has become confused with confidence. Of importance here is the quality of the environment and the experiences students have while gaining clinical experience. In the early comprehensive nursing courses there were some things that students were simply unable to do. As Judith Christensen (1978:4) points out this was because

... restrictions in the various clinical areas encountered during the programme will have provided the students with limited experiences in some nursing skills such as the administration of medications and some infrequently used procedures. These restrictions may arise from several causes including the number of hospital-based students in the particular unit, and local policies such as registered staff administering medications as well as a lack of understanding about the student's learning needs by the staff in the ward.

Taylor et al (1981) identify in the evaluation of the technical institute courses that there were difficulties in relationships between the graduates of the new courses and their nursing colleagues as a direct result of the changed nursing education system. In particular, some criticism came from students of the hospital based programmes in areas where dual systems of nursing education remained, and from some staff nurses who reported feeling threatened by the new kind of training, and with the notion of comprehensive registration. Overall, however, it was determined that relationships between new graduates and their colleagues was not an issue. This, however, was not necessarily the experience of individuals during their time as students. As Marie Burgess (1984:68) notes:

In clinical situations the resistance to change showed up in individual staff members, doctors and nurses, some of whom were anything from unco-operative to hostile toward technical institute students, their tutors and the new courses. During the early years both students and tutors, particularly the pioneers ...weathered some painful experiences at the hands of professional colleagues.⁸

Interpersonal relationships with colleagues, while important, are not the most significant issue here, although there may well be an interrelationship between the two. As the research of Miller (1978), Perry, (1985), Horsburgh (1987) and Clare (1991) has shown, once graduates enter the workforce as registered nurses, there is an expectation from other nurses that they will become like them. Thus although the clearly stated aims of the comprehensive nursing courses included the preparation of a practitioner who could function differently, in the reality of the practice environment, new graduates were expected to conform to 'the way things are done here'. Difference was not tolerated.

For newly graduated nurses coming from an education process in which the emphasis was on patient-centred nursing and problem-solving, it is hardly surprising that there was a clash of value systems. It can be seen that there are two competing discourses in ways of practising as a nurse. The new graduates had an educational preparation which emphasised holistic patient-centred care, and for those nurses already in the workforce, there was the custom and practice of working in a task-oriented system. Expectations that new approaches to nursing care could be influenced by this new type of nurse failed to take into account the

⁸ The writer experienced this hostility personally during 1976 while employed as a tutor in a part-time capacity at a polytechnic as well as being employed part-time in a hospital as a staff nurse. Students and tutors were identified from others by the wearing of a different coloured uniform. As a tutor, wearing a blue uniform while supervising students I was considered an outsider. As a staff nurse in a white uniform in the same hospital on different days I was 'one of them' (the nurses). On one occasion a colleague asked me why I worked at the polytechnic as a tutor when I was 'such a good nurse'.

hegemony in the health sector environment from those nurses who had been practising in a particular way for many years - firmly entrenched in task-systems of nursing care delivery and the biomedical model. As Judith Clare (Perry, 1985:49) so clearly points out: "(t)he knowledge these graduates brought with them to the practice setting was not valued to the same extent as was efficiency in practical skills". Thus in order to survive, it is incumbent upon new graduates to conform to another discourse by adopting the behaviours and attitudes of the experienced nurses in the workplace environment (Perry, 1985; Horsburgh, 1987; Forbes, 1990; Clare, 1991).

This analysis of the perceived shortcomings of the graduates of comprehensive nursing courses illustrates the point Foucault (1982) makes in relation to how power is exercised in "forms of institutionalization". These, he says

may mix traditional predispositions, legal structures, phenomena relating to custom or fashion ... they can also take the form of an apparatus closed in upon itself, with its *specific loci*, its own regulations, its hierarchical structures which are carefully defined, a relative autonomy in its functioning ... they can also form very complex systems endowed with multiple apparatuses ... (Foucault, 1982:223).

The shift in nursing education represents a discontinuity or break in the dominant view of the nurse. The nursing identity produced through this new system of nursing education, created a different subjectivity. Power relationships made it difficult for this nursing identity to be anything other than what the dominant view was. Thus the new graduate nurses were "the effect of a production, caught in the mutually constitutive web of social practices, discourses and subjectivity" (Henriques et al, 1984:117). In utilising Foucault's approach to power by which to analyse how power is exercised in the construction of the nursing identity, it can be seen that power does not act directly or immediately on people. Rather, it is

... a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult: in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects (Foucault, 1982:220).

Governmentality and nursing education

Despite the statutory authority bestowed on the Nursing Council of New Zealand for the governance of nursing education courses, there has been considerable involvement of the State in nursing education, since the transfer of nursing education commenced. Various Ministers of Health and of Education were represented on such committees established to monitor nursing education through government officials, as were nominees from "stakeholder" groups, such as hospital boards, polytechnics, the New Zealand Nurses Association. Also included has been representation from the New Zealand Medical Association.

An example of such a group was the Nursing Education Review and Advisory Committee (NERAC) which was established in July 1980 to monitor nursing education in New Zealand and report to the Minister of Education. This committee followed the disbanding of an earlier committee which the Minister of Education established as a result of one of the recommendations of Carpenter (1971). Primarily, its brief was to advise the Minister of Health on the appropriateness of the new nursing education programmes to the needs of the health service (Burgess, 1984). Despite the existence of this group, continued antagonism towards the introduction of comprehensive nursing courses was evident in the blame apportioned to this system for a shortage of registered nurses during the mid-1980s. Nurses appeared to be moving out of the health sector in alarming numbers. The shortfall of registered nurses was estimated in 1986 to be between

700 and 1500 nationally (NZNJ, January 1986:9). But as Yvonne Shadbolt (1991) identifies, the main focus of attention moved away from the real issue of the maintenance of a nursing workforce, to the preparation and beginning practice of registered nurses.

As a result of the perceived crisis which might result from a predicted shortage of registered nurses, in 1986 the Department of Health sponsored a workshop which subsequently became referred to as the Review of the Preparation and Initial Employment of Nurses, which became known as RIPIEN. A selected group of people from a widely representative group of nurses, consumers, medical practitioners and government officials were invited to participate in this workshop. The perceived concerns about nursing education are reflected in the terms of reference for this workshop, which were

- 1 To explore issues in the preparation of nurses for employment in the health services.
- 2 To identify ways to improve the distribution and retention of newly qualified nurses in the workforce.
- 3 To identify ways of facilitating the completion of the transfer of nursing education.
- 4 To provide a forum for debate and a framework for public information.
- 5 To develop strategies for future action (Department of Health, 1986:1).

The workshop participants identified sixteen priority issues for nursing and nursing education (refer to Appendix 2). The work commenced at this workshop did not disappear, and many of the issues remain as significant for nursing education today as they were over ten years ago.

From the 1986 RIPIEN workshop, a committee known as the National Action Group (NAG) was established to implement and monitor the achievements that were suggested in the sixteen priority issues identified in the workshop (Boyd, 1991). Although NERAC was disbanded in 1986, the National Action Group continued to address and monitor issues identified in the RIPIEN report. Although it was considered that the work of NAG needed to continue, its source of funding required annual reapplication to the Department of Health workforce development fund (Boyd, 1991). Refocusing - or downsizing - of the Department of Health into a smaller Ministry of Health in 1991 as a result of the health reforms of the National Government elected in 1990 meant that this source of funding disappeared, and so too did the National Action Group. But there has been ongoing surveillance and monitoring of nursing education courses through various groups and committees and it must be considered that these would address any issues arising with perceived deficiencies in nursing education. Given that these committees have had the ear of various Ministers of Health and Education, it has to be assumed that no complaints were ever made which would alter the direction of nursing education courses in polytechnics.

This chapter has focused on the relocation of nursing education into the general system of education in New Zealand and struggles associated with this, as well as exploring how power is exercised in relation to the dominant view of the nursing identity. Despite the agreement to have nursing education located in technical institutes following the recommendations of Helen Carpenter in 1971, it may not have been anticipated at that time that these institutions would be able to confer degrees as a result of legislative amendments. The 'reform' of tertiary education in New Zealand which commenced in the mid 1980s was to cause a further disruption to the dominant view of the nurse. Tensions apparent during the shift of nursing education from hospitals were again to arise, albeit with a slightly different

perspective. However, many of the tensions continue to relate to nursing's perception of an 'educated nurse', and the dominant view of the nurse which reinforces the technical aspects of activities that nurses undertake in nursing practice. This will be investigated in chapter eight. The next chapter will illustrate the interrelationship between knowledge and power in the discursive construction of the nurse through curricula.

CHAPTER SIX

CURRICULA AS REGIMES OF TRUTH

This chapter provides an analysis and critique of curricula used in nursing education. The influence of curricula in discursively constructing the nurse within particular discourses is clearly a significant issue that warrants careful analysis. As identified in chapter four, what was contained within a national curriculum for nursing education was highly prescriptive, and for almost seventy years, was determined by statute. Nurses Regulations, initially enacted in 1908 outlined in specific detail what was to be taught in nursing education programmes, and curriculum guidelines were developed in accordance with these regulatory prescriptions. The effect of these regulated guidelines was to embed nurses and nursing in what is referred to as the 'biomedical' model, from which schools of nursing had little opportunity to deviate.

To clarify what is meant by this model, it is helpful to summarise what its assumptions are. According to Blattner (1981:7) some of these include

1. All aspects of health can be understood in physical and chemical terms.
2. The aim of medical science is to analyze the structure and function of the human body in more and more detail.
3. The prerequisite basic sciences in the study of medicine are anatomy, physiology, biochemistry, molecular biology, and microbiology.
4. Study of the mind and its pathology is a separate medical specialty known as psychiatry.
5. Therapy consists of physiochemical interventions on the body machine.

The shift to comprehensive nursing courses during the 1970s brought about a change in the organisation of curricula, in terms of a greater degree of freedom for schools of nursing to develop a curriculum of a more individual nature within relatively broad guidelines than the previously heavily prescribed curriculum guidelines. As well, there was a different knowledge base developing for nursing able to be utilised in curricula. This was the result of North American nurses developing broader nursing models than the biomedical model, and was to be influential on nursing education curricula in New Zealand.

Each of these curriculum structures reflect, however, what Foucault (1980) refers to as a “regime of truth”, in that within them, relationships between power and knowledge can be highlighted. It is not so much a matter that particular regimes of truth have emerged at various times that is at issue here, but rather how this happened that is of concern in this chapter. Assumptions and values associated with nursing education curricula and how these came to influence nursing education in New Zealand will therefore be examined in this chapter. The significant influence of the ideas of Ralph Tyler (1949) on nursing education is explored in some detail. But in order to understand how the curriculum in nursing education has been influenced by various factors, first it is important to clarify what is meant by reference to the term ‘curriculum’.

Curriculum

There is some contention about exactly how ‘curriculum’ should be defined. Carr and Kemmis (1986) identify several key questions about the precise focus in discussing or researching curriculum issues. In particular they ask:

To what extent is the curriculum to be found in a specific act of teaching or learning? To what extent does it refer to a programme of work across a whole year? To what extent is it to be understood in relation to historical circumstances and general educational policies? To what extent is it to be found in educational practices? To what extent does curriculum refer to general systems, and to what extent to human encounters? (Carr and Kemmis, 1986:20).

These questions highlight the complexity of issues associated with any venture into the field of curriculum, as well as the diverse meaning or definition of curriculum. As Stephen Kemmis (1986:20) asks: “What is curriculum? What kind of thing is it that we can or should have theories about it?”.

Stenhouse (1975:5) is critical of many curriculum definitions, because he wishes to place an emphasis on the relationship between educational principles and educational practice. In his view, curriculum is “... an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice”. This definition can be utilised as one way of exploring what is contained in nursing education curricula. In doing so the intention is not to privilege meaning but rather to provide a way in which to organise discussion about curriculum matters. Despite the number of questions that may be asked about curriculum, it is apparent that there is a plethora of definitions (Tyler, 1949; Johnson, 1967; Bevis, 1978)¹.

Influences and curriculum perspectives in nursing education

It is useful at this point to step back and examine some of the values, assumptions and beliefs in relation to nursing which have influenced curricula in nursing education. Bevis (1978), in addressing nursing curriculum development, suggests

¹ These are mentioned here because they highlight the influence of Ralph Tyler (1949) on curriculum. Johnson (1967) for example, defines curriculum in terms of a structural series of outcomes. For Bevis (1978) the curriculum represents those learning activities which achieve specific goals.

that nursing has utilised a variety of value systems which have directly influenced nursing throughout its history. These are defined as “*asceticism, romanticism, pragmatism and humanistic-existentialism*”. Bevis’ (1978) contentions in relation to these are summarised as follows:

Ascetisism - is associated with duty and servitude, obedience and self-denial. It can clearly be seen as a major value system in the Nightingale model of nursing and nursing education in the early history of nursing, as well as in the early days of nursing education in New Zealand.

Romanticism - is linked to the bio-medical model of fostering dependence on and subservience to the medical profession, and service. It also, perhaps more significantly, supported the subservient and idealised ‘traits’ of women, and can be regarded as a fundamental reason why there is such an intricate relationship between nursing issues and women’s issues. The idealised and romantic view of women became linked with an idealised and romantic view of nurses and nursing.

Pragmatism - is associated with the functional and the practical, and nursing’s move to specialised nursing practice following the tradition of medical specialities provides a good example of this value system. Nurses were required to have skills and knowledge associated with specialised medical areas, hence the emergence of nursing education programmes to prepare nurses for the maternity service, the psychiatric service, and the care of what was referred to as intellectually handicapped children, for which the psychopaedic nurse was specially prepared.

Humanistic-existentialism - reflects a general trend in society to become concerned with the notion of holism. Nursing absorbed this value system by becoming increasingly concerned with the whole person - the family - the whole community.

The primary characterisation of this value system was a high priority on caring about people. It is particularly evident in nursing education curricula developed around the emergence of comprehensive nursing education courses during the 1970s in New Zealand.

Although new ways of thinking about nursing emerged, previous value systems did not disappear but became less important. As Bevis (1978:33) notes: "Former value systems still operated, still influenced judgements and decisions, and still provided some material for nursing practice and educational behaviours". She argues that a philosophical statement or statement of beliefs about nursing within a curriculum will reflect the subsequent organisation of curriculum content. Later discussion in this chapter about curricula developed at various times in nursing education programmes in New Zealand illustrates this.

Bevis (1988) also identifies four turns in the development of nursing curriculum. The first was in the 17th century, from the French Sisters of Charity. The second came about as a result of the influence of Florence Nightingale, which commenced during the 1860s and continued into the early part of the 20th century. The third was the development of an American group - the National League of Nursing Education - which was influential for around twenty years between 1917 and 1937. During this time, commencing with the publication of a "Standard Curriculum for Schools of Nursing" (Bevis, 1988:28) various guidelines were published by this group which provided general and specific goals for curricula in nursing education. But perhaps the most influential and longest lasting 'turn', as will be seen later in this chapter, occurred when nursing education discovered Ralph Tyler's (1949) course syllabus on curriculum development. With the possible exception of the first 'turn' Bevis (1988) describes, nursing education in New Zealand can be seen to have been influenced in some way by the three other turns outlined here.

There have, however, been other influences on curricula for nursing education. In an historical analysis of curriculum concepts in nursing education courses, Longway (1972) identifies that curricula were organised according to the health needs of society at a particular time. She notes that prior to the 1950s curricula were organised according to a particular structure. The focus was disease and disease control, and courses were structured according to specific diseases, such as “tuberculosis nursing”, or body systems such as use of the term “orthopaedic nursing”, or particular patient care areas, such as paediatric or geriatric nursing. It must be said, however, that these particular patient care areas reflect the disease orientation of the medical model, the effect of which was to organise care according to defined medical specialty areas. This is what Bevis (1978) refers to as “pragmatism”. The various subject areas ordered in this way were allocated a specific number of hours to be undertaken within the duration of the nursing education programme.

Stevens (1971) in an historical analysis of the structure of curricula observed that several structural forms were apparent in nursing curricula, essentially according to four types: logistic, operational, problematic and dialectical. These structural forms have some similarity to notions of curriculum organisation suggested by Bevis (1978 and Longman, 1972). The logistic curriculum mode used a disease, body systems or patient care area approach. The operational mode focused on the student’s learning needs rather than the disease or the patient, whereas the problematic mode provided a list of problems as its focus. In the dialectical mode the organising principle of the synthesising ‘whole’ provided a basis from which the student learned according to a health-illness continuum or developmental life span approach. There is a similarity here with Bevis’ (1978) notion of *humanistic-existentialism*.

Assumptions and values of nursing curricula in New Zealand

Programmes within hospital schools of nursing in New Zealand during the 1960s demonstrate the organisation of curricula around 'body systems' which reflect medical specialties. The *Supplementary Instructions for the Training of Nurses* issued by the Nurses and Midwives Board in 1965, highlights the way in which the programmes were to be organised, and the number of hours required for each area in terms of theoretical and clinical aspects for general and obstetric nurses (Nurses and Midwives Board 1965:2-3). This is used for the purposes of this chapter to illustrate the discursive constitution of nursing education immediately prior to the proposed changes to the location of nursing education.

In terms of theoretical requirements, what is specifically referred to as 'Nursing Arts' consists of 350 hours out of a total theory syllabus of 536 hours, and these are divided into specific sections:

Nursing	120 hours
Obstetrical Nursing	50 hours
Paediatric Nursing	20 hours
Medical and Surgical Nursing and Specialties and Gynaecological Nursing	150 hours
Geriatric Nursing	10 hours

The remaining 186 hours over a three year period in which the programme took place consist of what is categorised as

Public Health and Social Services: 20 hours Public Health and Social Services, 20 hours Psychology and Mental Hygiene

Nursing Sciences: 120 hours Anatomy and Physiology, Biochemistry, Microbiology, Nutrition, Pharmacology

Profession of Nursing: 20 hours Nursing Trends and Professional Responsibilities

Ward Administration: 6 hours

The clinical experience requirements are outlined in terms of weeks and as minimum requirements. These too, are specified according to medical specialties

Introduction to Nursing	12
(Preliminary Training School) (25 days in clinical field)	
Obstetric Nursing	18
(This is to be given in two sections: Six weeks in first year; 12 weeks in third year)	
Medical Nursing.....	16
Surgical Nursing.....	15
Eye, Ear Nose and Throat, Urology, Orthopaedic Nursing	16
Gynaecological Nursing.....	6
Geriatric Nursing.....	6
Communicable Disease Nursing, including tuberculosis	6
Operating-theatre Nursing.....	8-12
Outpatients and/or Casualty Nursing.....	4
Public Health and/or District Nursing.....	4
Diet Kitchen Experience.....	2
Paediatric Nursing.....	12

The basis for these divisions into body systems or diseases is not stated. However, it can safely be assumed that the way in which hospitals were structured and people (patients) within them were categorised according to patient care areas and medical specialties, premised on the assumptions of the biomedical model, were significant

contributing factors. Categorising people into body systems also reflects the way in which the health system met the health care needs of society. Accordingly, nursing students were required to 'learn to be a nurse' through this approach.

It needs to be noted that the students, as the providers of care and employees of hospital boards, did not have any guaranteed correlation between theoretical aspects of particular medically constructed specialties and clinical practice. While there were guidelines about particular aspects of the programme being taught at specific times, this was not the overriding concern of employers of student nurses. Of importance here is that there was always a hierarchical system of student nurses, ranked in status from junior to senior. Within this structure it was common for students to work in areas of hospitals without any theoretical preparation. They may have been assigned to work in a particular hospital ward for a specified length of time in order to meet the requirements of the curriculum. But when another ward was short of nursing staff, it was not the learning needs of the students that took priority but the service needs of a particular hospital. Moreover, since the emphasis was on an ability to carry out tasks with great efficiency, the value of any theoretical content must be questionable anyway. If nurses learned the skills of caring for someone in an orthopaedic ward during their first year of training, yet did not undertake the theoretical component of "orthopaedics" until the second year of their nursing education programme, it raises issues about the whole process of learning and indeed about what it is that was actually "learned". It highlights differences in the notions of training and education, as well as the emphasis of preparing nurses for registration under the apprentice model as being concerned with what the nurse could do rather than what the nurse knew.

The curriculum of the 1960s prescribed in these *Supplementary Instructions* appear to have no significant concern with the learning needs of students nurses, and the

emphasis is on the product of the programme. What nursing programmes were required to do was

1. To give the student nurse a sound clinical and theoretical basic nursing education so that she can through all stages give good nursing care to her patients.
2. To give the student nurse a course of nursing education which includes maternity nursing in a three-year period.
3. To give the student nurse a course of nursing integrated throughout with public health and preventive medicine so that she may take her place as a useful member of the health team.
4. To give the student nurse opportunity to work not only in the hospital but in related health fields (Nurses and Midwives Board, 1965:29).

Within the wider context of health, the changing nature of diseases and their treatment influenced medical practice, and, in turn, nursing education. Apart from specifically prescribed hours for each student nurse to complete in terms of theoretical and clinical requirements, there was also a specified format which detailed exactly what was to be “learned”. A body systems approach which outlined the disease, the medical treatment, and the nursing techniques and skills associated with implementing the treatment was the essence of nursing education curricula. The primary focus was the teaching of diseases and conditions associated with a particular body system; the nursing aspect was in one sense, an adjunct. Student nurses were taught by medical practitioners who came in to schools of nursing to teach about a disease and its treatment. Registered nurses employed as tutors taught nursing procedures and techniques associated with a particular disease or condition and its treatment. Textbooks used in the nursing programmes were a reflection of this model, and these were generally authored by medical practitioners and may or may not have had nursing input (for example Toohey’s *Medicine for Nurses* (1962) and *Surgery for Nurses*, (Wilson and Harlow, 1968) used in the Christchurch School of Nursing during the 1960s).

The prescriptive curriculum requirements of the Nurses and Midwives Board at this time detailed what was to be the content for nursing education programmes according to body systems. The justification for this approach was that "... by commencing with the system in detail the normal is given first. As the diseases and disorders are discussed it follows logically that (the other) factors affecting health and illness will dovetail in" (Nurses and Midwives Board, 1965:18). The emphasis is clearly on pathophysiology. The skeletal and muscular system has been outlined here simply as a framework to show how this was planned to occur.

SKELETAL AND MUSCULAR SYSTEM

- 1 Anatomy and physiology.
- 2 Medical and surgical disorders - Bones: sprains, strains, dislocations, fractures and amputations, bone grafts, bone infections common deformities, arthritis and fibrositis.
Joints: arthritis, bursitis, rheumatoid arthritis.
Muscles: trauma, fibrositis.
 - (a) Microbiology - As relating to above conditions.
 - (b) Pharmacology - As relating to above conditions.
 - (c) Nutrition and diet therapy - As relating to above conditions.
 - (d) Nursing Arts - Application of splints, traction apparatus, special appliances; application and removal of plaster, application of heat, early ambulation. Care of patients suffering from above diseases and disorders.
 - (e) Public health and health education - As relating to the above conditions, prevention.
 - (f) Psychology and mental hygiene - Effects of prolonged incapacitation.
 - (g) Socio-economic - Adjustments necessary.
 - (h) Rehabilitation - As applied to above conditions.
- 3 Obstetrics - Effect of disease and injury on childbearing.
- 4 Paediatrics - Congenital dislocations and deformities in handicapped children.
- 5 Geriatrics - As pertaining to above (Nurses and Midwives Board, 1965:20).

There are nine body systems identified and outlined in this way in these 'curriculum' instructions. This aspect of nursing education curricula of the (not so distant) past² has been detailed to this extent here as a way of highlighting several key points. First, the content of nursing curricula can be seen to be entrenched within the medical or disease model in that the knowledge component the student is required to learn relates to diseases, medically defined conditions and disorders. Second, the nursing component is associated with particular skills of a technical nature which are seen to be required for nurses to provide care to patients who fit within these categories, conditions or disorders. And third, the nursing component has to be seen as an adjunct to the medical aspects of the condition or disease. These factors exemplify the way in which nursing knowledge and skill requirements emphasised technical rationality at this time. The notion of technical rationality will be discussed in chapter seven.

The shift in nursing education from the hospital environment provided the opportunity for the development of a different curriculum structure with a change of focus from the biomedical model to models which had a greater focus on nursing knowledge and skills.³ But this curriculum structure was also influenced by what was happening within the general system of education in terms of an approach which outlined specific behaviours that were to be "learned" within a given curriculum, which came from the influence of Ralph Tyler.

2 It is this curriculum which represented for many registered nurses, currently practising in New Zealand the "knowledge" or "regime of truth" about nursing. Since it was operative until the late 1960s it is this that shaped the knowledge base of many nurses still in practice.

3 This was essentially because the Nursing Council of New Zealand, could not exercise the same prescriptive curriculum requirements over comprehensive nursing courses located within the tertiary education system. Each polytechnic was autonomous in terms of the Education Act.

Desired behaviours - the influence of Tyler on nursing education

The establishment of comprehensive nursing courses in the polytechnic system and the desire to have a new 'type' of nurse, created a space for a shift in thinking about curricula. New Zealand nurses with responsibility for nursing education were influenced in this regard by American ideas about nursing and by texts relating to curriculum development. As Judith Christensen (1989) notes, the continued medical orientation of British nursing and the lack of New Zealand nursing literature led to utilisation of conceptual frameworks which were becoming abundant in the American literature. Nurse tutors, no longer constrained by a nationally prescribed curriculum or the demands of a hospital, were challenged to develop curricula which reflected the changing pattern of health care in New Zealand and provide a nursing education course which would encompass the knowledge and skills required of a comprehensive nurse.

An important influence on nurse educators in New Zealand at this time was Em Bevis, an American nurse educator who published a book on curriculum development for nursing (Bevis, 1973, 1978). Using a framework heavily influenced by Tyler, this book became influential in nursing education. The essence of her framework was a belief that any curriculum for nursing should ensure that knowledge required for students of nursing to become registered nurses met some sort of criteria. For Bevis (1978:8), the emphasis was on structuring a curriculum so that it was possible to do three things

- (1) determine the behaviours desired of the product,
- (2) devise a system of experiences that will produce the specific desired behaviours, and
- (3) discover whether the product exhibits the desired behaviours

This prescription for a curriculum structure outlined by Bevis (1978) illustrates how Tyler's (1949) curriculum prescriptions had now become the "regime of truth" for nursing education curricula. Bevis, in effect condenses questions Tyler (1949) proposes in relation to curriculum planning. Tyler (1949) poses four fundamental questions which, he asserts, must be addressed in curriculum planning and development

- 1 What educational purposes should the school seek to attain?
- 2 What educational experiences can be provided that are likely to attain these purposes?
- 3 How can these educational experiences be effectively organized?
- 4 How can we determine whether these purposes are being attained? (Tyler, 1949:1)

In the selection of learning experiences, Tyler (1949:67-68) identifies several general principles, which he outlines as

- 1 The student must have experiences that give him an opportunity to practice the kind of behaviour implied by the objective.
- 2 The student must obtain satisfaction from carrying on the kind of behaviour implied by the objectives.
- 3 The reactions desired in the experience are within the range of possibility for the students involved.
- 4 Many particular experiences can be used to obtain the same educational objectives.
- 5 The same learning experiences will usually bring about several outcomes.

The learning experiences, once selected, needed to be organised so that they reinforced each other. Tyler (1949:84-85) proposed three criteria by which to do

this - continuity, sequence and integration. Along with the use of objectives by which to specify learning activities and how these would be measured, curricula also included various vertical and horizontal strands which represented the criteria of continuity, sequence and integration.

Prescribing behaviours

In November 1977 the Nursing Council of New Zealand issued a set of “supplementary instructions” which were essentially curriculum requirements for comprehensive nursing courses (Nursing Council of New Zealand, 1977). They were necessary because there was no specifically prescribed content for the new courses in the existing Nurses Regulations. These instructions were clearly influenced by Tyier’s (1949) rationale for curricula, and are reproduced here in full to highlight this point.

AIM

To prepare a person in a student based programme for comprehensive nursing practice in any setting.

OBJECTIVES

In any area of nursing, the registered Comprehensive Nurse will be able to:

1. *Identify and define specific nursing problems and in collaboration with the individual(s) concerned, plan, implement and evaluate nursing care appropriate to the needs of that person.*
2. *Integrate knowledge from the various areas of nursing and related studies in the planning and provision of nursing care.*
3. *Contribute a specific nursing component to the activities of the health team by assisting in the creation and maintenance of an environment that enables individuals and families to achieve realistic health goals.*
4. *Accept responsibility for personal nursing practice and life long education.*

ORGANISATION

The programme to be planned and implemented on the basis of:

Philosophy which:

1. *Is clearly stated.*
2. *Is formulated, accepted and frequently reviewed by staff.*
3. *Expresses beliefs of the staff concerning nursing and the teaching-learning process.*
4. *Incorporates current concepts of nursing and education.*

Aims and Objectives developed by the school to fit within the aim and objectives specified. Objectives at all levels of the curriculum are to:

1. *Derive from the programme objectives.*
2. *Form the basis for planning, implementation and evaluation of the curriculum.*
3. *Identify behaviours expected of the beginning practitioner.*

Curriculum which in plan and presentation:

1. *Identifies central themes which are integrated and developed sequentially.*
2. *Allows for integration of clinical and theoretical experiences.*
3. *Includes course outlines which specify:*
 - course title and description*
 - objectives*
 - outline of content*
 - learning experience for achievement of objectives*
 - evaluation methods*
4. *Is available in written form to tutors, students and Council.*

Evaluation System which forms an integral part of the curriculum and incorporates:

1. *A stated policy on evaluation of student progress which is made known to students on entry to and at intervals throughout the programme.*
2. *Evaluation of student progress in terms of the specified competencies expected at different levels in the programme.*
3. *Involvement of students in evaluation of their own theoretical and clinical performance.*
4. *Systematic and ongoing evaluation of the curriculum by tutors and students.*

A marked shift of emphasis from the previously prescribed body systems approach outlined earlier in this chapter for students undertaking hospital based programmes which led to registration as a general and obstetric nurse is apparent in these instructions. Of note also is that the content for the comprehensive nursing courses was less prescribed than the hospital based programmes, but nonetheless there is a clear requirement to utilise a specific curriculum approach. The instructions can be seen to encompass the values and assumptions underlying the desire to have a registered nurse with a comprehensive preparation, able to practice in a variety of clinical areas upon registration.

Curricula submitted to the Nursing Council of New Zealand for approval were able to have considerable flexibility in terms of choice in relation to particular frameworks, but each curriculum had to include particular studies and minimum hours according to the Scheme for the Registration of Comprehensive Nurses (Nursing Council of New Zealand 1977:11), which were:

STUDIES RELATED TO NURSING

These are to be directly related to nursing and must not exceed 50% of the total theoretical content of the programme.

Physical and biological sciences:

Physics
Chemistry
Biochemistry

Anatomy and physiology
Pharmacology
Microbiology

Behavioural and social sciences:

Psychology
Sociology

Communications
Human Growth and Development

NURSING STUDIES

Nursing theory and concurrent clinical experience encompassing the range of nursing practice associated with:

Community Health
 Family Health including Obstetrics and Paediatrics
 Medicine and Surgery
 Psychiatry and Psychopaedics

Nursing studies to include the application of knowledge from physical, biological, behavioural and social sciences and the development of nursing knowledge, professional attitudes and skills in:

- 1 assessment, planning, implementation and evaluation of nursing care for -
 - people in varying stages of the life cycle and in varying degrees of dependency
 - individuals, families and groups
 - people with health problems from all aspects of the health-illness spectrum
- 2 contributing a specific nursing component to the activities of the health team.

MINIMUM HOURS FOR REGISTRATION

Each student must have completed:

Theoretical Content	1500 hours
Clinical Experience	1500 hours

While these were not enshrined in legislation they were issued by the Nursing Council as part of the *Supplementary Instructions*, since the Nurses Regulations 1973, promulgated from the Nurses Act 1977 did not provide for comprehensive nursing courses, and regulations had not yet been written following the enactment of the Nurses Act 1977 which was to come into force on 1 January 1978. ⁴

⁴ The first regulations to be promulgated from the Nurses Act were the Nurses Regulations 1979. They did not specify requirements for hours or content of curricula for comprehensive nursing courses as earlier Nurses Regulations had for hospital based nursing programmes. Instead they specified the requirements for the length and the location of the nursing course and for the State Examination for comprehensive nurses (Regulation 3). The Nurses Regulations 1986, which are the current regulations, continue to make this provision.

Given the key elements of Tyler's curriculum model clearly apparent in these "instructions" from the Nursing Council, it is not difficult to see how those responsible for nursing education curricula had to demonstrate the inclusion of these features in a curriculum in order for approval to be obtained.

As will soon be identified in chapter seven, the changing nature of knowledge in nursing and the introduction of 'the nursing process' which influenced nursing practice also had an influence on nursing education curricula. An emphasis on nursing became apparent and the biomedical model is said to have been de-emphasised. Nonetheless there is a clear and unmistakable emphasis on continuity, sequence and integration. In a report published in *Kai Tiaki* in 1978, polytechnics which established the first comprehensive nursing courses it is possible to identify new, and in particular, Tylerian influences in the way that these courses were organised. The focus for one course was " .. the interaction by means of the nursing process between the nurse and man in states of equilibrium and disequilibrium ... medical science takes its place with other associated subjects as supportive knowledge to facilitate the role of the nurse" (Christensen, 1978:3). Another course states the central theme of its curriculum as "... providing nursing care according to the patients needs as they vary at different stages of the life cycle. The first two terms are spent learning basic nursing skills as part of the nursing process. Practice and theory are correlated" (Seymour, 1978:6).

Criticisms of the objectives curriculum model

Although Tyler developed his systematic approach to curriculum planning with an emphasis on the achievement of particular objectives by the student, his emphasis was on three domains of learning from which objectives were to be specified. These areas, that is, understanding, skills and appreciation, were not stated as

specific behaviours which were subsequently able to be evaluated. Benjamin Bloom (1956) refined these domains further into cognitive (intellectual skills), psychomotor and affective.

Nursing curricula during the 1970s organised course content into these three domains developed by Bloom as knowledge, skills, and attitudes. However, as Reilly (1990) notes, these domains were open ended in terms of teaching and learning activities and evaluation strategies. It was Mager (1962) and his colleagues Krathwohl et al (1962) who developed the work of Tyler further with the inclusion of specific behavioural objectives as well as all the conditions of learning and criteria for evaluation. Tyler may have developed the platform from which specific behavioural objectives were to eventually be launched, but the primary emphasis of his curriculum approach seems to be more about systems theory in which a curriculum evolves in a logical format from a basic philosophical premise to which all other components are related through to evaluation. Cleo Cherryholmes (1988) makes an important point when he notes that Tyler's approach to the development of curriculum provides a guide for educators to think in a systematic way about curriculum and instruction. It is the four questions he postulates rather than the issue of objectives which impose structural assumptions on educational thought. Objectives, by themselves hold little meaning. Thus criticisms of Tyler in terms of behavioural objectives may be misdirected and might be better focussed on the structures he proposes which influence curriculum process and content. But it might also be worth considering that for nurse educators, bound to a structured set of instructions from the registering authority for nurses, and subjected to criticisms about graduates from nursing courses, that the objectives model inherent in Tyler's framework, was a way of justifying what material had been "taught".

In exploring criticisms of Tyler and his approach to curriculum planning and

development, however, it can be seen that the main arguments do seem to lie with the issue of objectives. In terms of the requirements of the Nursing Council of New Zealand (1977) outlined earlier, the obligation to have predetermined objectives and criteria which are able to be measured to determine whether or not they have been achieved are clearly apparent. Despite the influence of the objectives model of curriculum initially developed by Tyler (1949) there have been many criticisms of the place of objectives in curricula. The main criticisms have been summarised by Reilly (1990) who points out that there are five common arguments against their use in nursing education. These are said to be that

- 1 Behavioural objectives are derived from behaviourism, a natural science of learning, and thus are incompatible with other learning theories from the human sciences.
- 2 Predetermined objectives express the teacher's expectation of the outcome and do not provide an opportunity for the student to seek own objectives.
- 3 They interfere with the freedom to learn and teach and thus stifle the creative process.
- 4 Their precision is incompatible with a complex field of study such as nursing.
- 5 They require more time for development than is warranted by their effect in the program.

Reilly (1990), in arguing for the use of objectives in curriculum clearly wants to differentiate between educational objectives and behavioural objectives. The former, she asserts, may be used to identify the intended outcomes of an educational programme. Behavioural objectives, on the other hand, communicate expected behaviour which signifies the learner's achievement. She emphasises that they serve two key functions for educators; first they provide a clear statement of what it is expected that students will learn, and second, they challenge appropriate evaluation of that learning. Thus they can be seen as fair in the sense that they

evaluate only what it is stated will be evaluated. However, it is precisely this aspect which critics condemn.

The objectives model used in nursing education curricula which was founded on Tyler's principles is seen as a "technical-rational" approach which is based on premises that follow a rational plan in which the means cannot be chosen until the ends have been identified. This means that emphasis is able to be placed on those aspects of nursing that can be objectified or for which certain behaviours can be identified and the student measured against them in terms of achievement or otherwise. In this way there is a particular element of control over the content of what it is that is seen to be essential for students to learn within an educational programme. As Judith Clare (1991:11) notes: "The nature of knowledge which forms the epistemological basis to the curriculum is unquestioned, and the hierarchical relationship between teaching and learning is considered unproblematic". It is this that seems to be of paramount importance to critics of a Tylerian curriculum structure. Cleo Cherryholmes (1988:41) points out that Tyler's rationale is silent on issues such as choice, because there is "... no discussion of decision-making, politics, ethics, social criticism, social responsibility or critical reflection". Thus there is no context, because what is constructed reflects the power arrangements and dominant ideology of the time (Cherryholmes, 1988). The result is that

Tyler's rationale gives the appearance of order, organization, rationality and enlightened educational control and engineering. But it does not deliver in terms of criticism and choice. Its rhetorical claims exceed its logical argument. The effect, therefore, is to reinforce current educational discourses-practices, along with their supporting ideologies and power arrangements. The rationale endorses things the way they are ... (Cherryholmes, 1988:41-42).

The implications of the continued use of the objectives model of curriculum organisation is that there is an emphasis on the acquisition of technical skills. This promotes an artificial separation of knowledge from those who may conceptualise it, the central feature of which is control, as knowledge is structured in such a way within the curriculum that it can be seen to be linked to principles of social and cultural power (Bernstein, 1975). In such a model where “transfer of knowledge” occurs, as Freire and Shor (1987) point out, theory is regarded as the basis for practice, rather than being seen as an integral part of practice. Within this model the teachers of student nurses are in effect transferring their knowledge to the students and thereby reinforce the perpetuation of separating knowledge from practice. Stenhouse (1975) is critical of the objectives model of education for this reason. He claims that this approach “... attempts to improve practice by increasing clarity about ends. Even if it were logically justifiable in terms of knowledge - and it is not - there is a good case for claiming that it is not the way to improve practice” (Stenhouse, 1975:83). The use of an objectives model for curricula therefore makes knowledge instrumental.

Alternative views of curriculum

Stenhouse (1975) claims the objectives model is more suitable in an educational programme in which the intention is information and skill. He argues for a process curriculum model, which he asserts is “more appropriate than the objectives model in the areas of curriculum which centre on knowledge and understanding” (Stenhouse, 1975:97). If Stenhouse’s view is applied to nursing education which prepares a nurse to undertake particular activities in the health system rather than for a specific role within the structure of a hospital, then it can be seen that there is a shift in the way that a curriculum is to be organised in nursing education. It suggests that the emphasis should not be on the acquisition of information and skills but on knowledge and understanding. This view could be seen to be at

variance with public expectations about information and skills nurses need to have and what they should be able to do on registration and subsequent entry into the workforce, and position the nurse according to the acquisition of practical skills. But the emphasis on education is different. This is articulated clearly by Bottorff and D'Cruz, (1985:3) who say

The two primary functions of education are, firstly, the relational transmission of important aspects of culture, and, secondly, the development of a capacity to distance oneself from that which one has been initiated into, in order to make judgments on it. Even though it is vital for people to be initiated into a particular culture, if the element of distancing were to be omitted the result would be mere socialization. The educated person is one who can form judgments not only on particular issues within the context of a cultural tradition, but one who can also critically reflect on the cultural tradition itself. Such a person should be able to decide on a reasoned examination of the evidence and to accept, reject or modify any particular aspect of the cultural traditions into which he/she has been initiated.

While it can be seen that nursing education curricula have been structured and organised according to a multiplicity of influences, it can be seen that the behaviourist assumptions of the Tyler model are not easy to escape from. Changing the curriculum from an objectives model as a particular "regime of truth" is one way to assist in the removal of the nursing education from its discursive constitution within the discourse of training with its emphasis on doing. In chapter eight, the assumptions of the "curriculum revolution" will be investigated as an attempt to do this. First, however, the link between the nursing education curriculum and the notion of knowledge needs examining, and this is the focus of the next chapter.

CHAPTER SEVEN

KNOWLEDGE POWER AND TRUTH

Our basic assumptions about the nature of truth and reality and the origins of knowledge shape the way we see the world and ourselves as participants in it (Belenky et al, 1986:3).

The shift in nursing education discussed in chapter five illustrates one aspect of a struggle to provide education for nurses within a different structure and with a knowledge base more comprehensive than the biomedical model. The assumptions and beliefs about the content of nursing curricula discussed in chapter six, identified how particular regimes of truth about what nurses needed to know prevailed in nursing education within hospital based programmes. The influence of the biomedical model in nursing education, with its emphasis on understanding health - and deviations from health in physical and chemical terms is clearly apparent in prescribed curricula for nursing education programmes. In order to understand how this model has been so dominant in nursing education, as well as illustrating the knowledge in relation to nursing, it is helpful to explore the notion of knowledge. The purpose of this chapter, therefore, is to explore and analyse issues in relation to the notion of knowledge with particular emphasis on knowledge in nursing education and how this has influenced the construction of the nurse. It is concerned with the interrelationship between knowledge, power, and what is defined as 'truth'.

To provide an analysis of knowledge and its significance to the argument of this thesis, this chapter first explores notions of knowledge by locating it in the context of paradigms. Then various aspects of knowledge are examined. This includes how knowledge is perceived, ways of knowing in nursing, the use of knowledge in

nursing education, and the place of theories and models as nurses attempt to understand and define nursing.

Different types of knowledge invite different levels of status, in academic and professional terms (Eraut, 1985). What is argued in this chapter, is that nursing knowledge represents what Foucault (1980) refers to as belonging to a field of “subjugated knowledges”. By this Foucault claims he means two things

on the one hand I am referring to the historical contents that have been buried and disguised in a functionalist coherence or formal systemisation ... Subjugated knowledges are thus those blocs of historical knowledge which were present but disguised within the body of functionalist and systematising theory, and which criticism - which obviously draws on scholarship - has been able to reveal. On the other hand, I believe that by subjugated knowledges, one should understand something else, something which is altogether different, namely a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity (Foucault, 1980:82-83).

Analysis of the discourses of knowledge and the discursive practices of these discourses is able to illustrate that certain knowledge is privileged. How nursing knowledge(s) came to be “subjugated knowledges” is related to the production of truth claims in discourses which privileges particular knowledge, because that knowledge is accorded more value. Foucault’s ideas of discourse show the historically specific relations between bodies of knowledge, or disciplines, and forms of social control, defined as disciplinary practices (McHoul and Grace, 1993). In relation to this it will be seen in this chapter that the discourses of medicine and gender have been dominant in the history of nursing knowledge, and that this has contributed towards the subjugation of nursing knowledge(s). It is helpful, therefore, to consider the construction of knowledge within various paradigms or discourses.

Paradigms, discourses and knowledge

There is clearly an interrelationship between paradigms, research traditions, discourses and the way that knowledge is perceived and accepted.¹ According to Kuhn (1970), science is ruled by frameworks or paradigms, and a paradigm defines what are researchable questions and what the boundaries are for investigation within that framework. While a paradigm may be regarded as a guide for investigation, it is seen as more than that. Denzin and Lincoln (1994:99) see a paradigm as “a set of basic beliefs that guide action” in which three dimensions exist; *epistemology* which is concerned with “How do we know the world? What is the relationship between the inquirer and the known?”; *ontology*, which addresses questions about the nature of reality, and *methodology*, a third paradigm dimension has as its focus how knowledge about the world is gained.

Denzin and Lincoln (1994:108) point out the inter-relationship between these three dimensions and note that three fundamental questions constrain the answers to questions in any inquiry. The ontological question addresses the form and nature of reality in terms of assumptions about a “real world”, how things are and how they work within this world of reality. This means that only those things that relate to this defined reality are admissible. Anything else comes outside the realm of legitimate science. Examples of what comes outside this realm would be questions concerning matters of aesthetic or moral significance. The epistemological question addresses the nature of the relationship between the knower and what can be known. However, the answer to this question is constrained by the answer already given to the ontological question in that it is not appropriate to postulate just any

¹ It must be noted that Kuhn's notion of a paradigm in *The structure of scientific revolutions* was in relation to the natural sciences. Foucault's references to science were normally to the human sciences.

relationship. If the knower assumes “real” reality, then in order to discover how things really work, a position of objective detachment must be adopted.

The third question is the methodological question which addresses the way in which the person seeking to know goes about finding out what it is believed can be known. But again, the answer to this question is constrained by the answers already given to the first two questions - that not just any methodology is appropriate. The significance of this is that the dimensions of various paradigms are interconnected. If someone was seeking to develop knowledge about the educational experience of any person seeking to become a nurse, for example, the three dimensions would need to be consistent in determining the answer.

Kuhn's central ideas about paradigms are important in any discussion of knowledge. They are particularly important in discussing nursing knowledge, because many nurses have followed Kuhn's thinking in relation to the development and organisation of nursing knowledge. During the 1980s, Fawcett (1984), for example, proposed a metaparadigm, that is a statement, or group of statements which identify a discipline's relevant phenomena, by which to structure and organise nursing knowledge. This consisted of four components: person, environment, health and nursing. Kuhn's assertions about the development of scientific knowledge are predicated on the notion of “revolution” whereby changes in views about the world are sudden and dramatic. Transformations in thinking occur; such shifts mean that new knowledge takes the place of old knowledge. Earlier paradigms are rejected because it is considered that the old way of thinking does not work any more (Kuhn, 1970).

While Foucault does not explicitly use the notion of paradigm in relation to his use of the notion of discourses, it appears that there are similarities between paradigms

and discourses. Just as discourses construct and position by producing knowledge as regimes of truth, so too, in one sense, do paradigms. Thus the way in which knowledge is constructed within a particular paradigm or world view highlights that paradigms are permeated with the workings of power and knowledge. For Foucault, knowledge is closely linked to the notion of truth. As he points out

Each society has its regime of truth, its 'general politics' of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each one is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, 1980:131).

It is within discourses that discursive practices form knowledge. As Flax (1993) explains they do so through the production of knowledge which legitimates power as well as experts. This in turn identifies and authorises 'truth speakers'. But since knowledge in one discourse is specific to that discourse, the 'truth' for that discourse is contextual and not applicable to all discourses. The rules for determining truth in one discourse simply cannot be transferred across all discourses, nor can any discourse be seen as either true or untrue because it is dependent on rules and context. Here can be seen the similarity between paradigms and discourses. The dimensions of epistemology, ontology and methodology outlined earlier of one paradigm provide the rules for the development of knowledge within that paradigm. In the same way, the rules for determining truth in one discourse cannot be transferred to another. What is seen as truth for one discourse may not be seen as truth for another.

If there are competing discourses it is not that the truth is greater in one discourse than it is in another, but rather that the effects of power determines the legitimation of the truth statements of a particular discourse and thereby its perceived dominance over another discourse. An example of this is the medical discourse about

childbirth, in which it is maintained that childbirth is normal only in retrospect. The midwifery discourse is that birth is a natural process that has become medicalised and “abnormalised”. However, the discursive practices of the medical discourse have legitimated medicine’s truth claims of the need for technology and intervention to produce “safer” births for women. This is pitted against claims that midwives are “unsafe” and lack “scientific evidence” for the basis of their practice (Papps and Olssen, 1997). Thus the discourse of medicine has power by eliminating or effacing other truth claims. The discursive practices are able to situate some voices as authoritative and silence or marginalise others. It is through study of discursive practices of discourses that knowledge and power is able to be analysed and understood.

Fiske (1993) suggests that if the word knowledge is used in a poststructuralist sense, that is as a knowledge or knowledges, the relationship between power and truth is able to be highlighted. In this view, truths, in the same way as knowledges, can be seen to be socially produced rather than singular and absolute. Knowledge therefore does not produce truth but power, or power disguised as truth. Thus, as Fiske (1993) explains, the social activation of knowledge through discourse can be seen as an agency of power. There is an inextricable link between social identities and ways of knowing, since the knowledge of reality involves knowing something in a particular way, and the power over what is accepted as reality is power to control. Thus the socio-political aspects of knowledge are evident in power relations. In addition, as Jane Flax (1993) asserts, if a discipline is to affect political discourse, it must acquire authority, since to claim such authority, scientific status is necessary. This, then, is part of the struggle for nursing - to have nursing knowledge accorded the same status as what is defined as ‘scientific’ knowledge. It may be, however that the discourses of nursing knowledge(s) are no more or no less ‘scientific’ than any other knowledge discourses.

Epistemology and nursing

The relationship between the three components of paradigms of knowledge notwithstanding, it is helpful to elaborate on the notion of epistemology at this point. Epistemology is a philosophical concept and can be defined as the study of knowledge or theory of knowledge (Flew, 1984). According to Sara Fry (1994:88), epistemology has generally centred on three questions:

1. What can be known or believed to be true?
2. What counts as criteria for the objects of knowledge?
3. How can one assert knowledge of himself/herself or knowledge of others?

Thus epistemology is concerned to determine how we know, what the rules for knowing are, and what the basis is for truth claims (Kelly, 1986).

Nursing epistemology, Schultz and Meleis (1988:217) suggest, can be considered as “... the study of the origins of nursing knowledge, its structures and methods, the patterns of knowing of its members, and the criteria for validating its knowledge claims”. They identify three types of knowledge which they claim are specific to the discipline of nursing. Clinical knowledge is considered to be that which results from a nurse engaging in a patient care situation in which multiple ways of knowing are used to deal with the a variety of patient problems. Is is seen as a combination of personal knowledge and empirical knowledge, but involves both intuition and subjective knowing. Conceptual knowledge is produced from reflecting on nursing phenomena. Patterns emerge in multiple encounters with multiple patients (Benner 1984). Empirical knowledge results from research which can be in any of the research paradigms.

Barbara Carper (1978) provides a view of the complexity of nursing's epistemology. She outlines four fundamental patterns of knowing in nursing: empirics, ethics, aesthetics and personal knowledge, and says that in any given nursing situation these components can be identified. Carper's fundamental question is "What kinds of knowledge are most valuable to the discipline of nursing"? It is helpful to summarise these patterns of knowing in order to determine the relevance of these for nursing knowledge.

Empirics is the term used to define knowledge gained through empirical processes of observation and testing theories. The emphasis is on the need for knowledge about the empirical world, and such knowledge can be organised into laws and theories which describe, explain and predict phenomena of concern to nursing.

Ethics is concerned with moral knowledge in nursing. Its focus is on matters of obligation in the sense that is concerned with what ought to be done. Within this domain, knowledge relates to ethical principles, ethical theories, different value systems as well as conflicts between these.

Aesthetics is used to describe the art of nursing or intuitive acts which nurses employ in their practice in terms of particular situations. The emphasis is not on uniformity and general laws; rather there is recognition that there are alternative ways of perceiving reality. It is concerned with interpreting meaning into action.

Personal knowledge relates to the knowing of self. Carper (1978:18) is careful to point out that what she means here is that "... one does not know *about* the self; one strives simply to *know* the self". The emphasis, then, is on knowing the self and the therapeutic use of self in relation to others.

The significance of the patterns of knowing outlined by Carper (1978) for nursing knowledge is that they illustrate the range of ways of using knowledge in nursing practice. Although they may be presented as particular categories, it can be noted that they are mutually dependent and not necessarily exclusive (Munhall and Oiler, 1989). As Carper (1978:22) asserts

Nursing thus depends on the scientific knowledge of human behaviour in health and illness, the aesthetic perception of significant human experiences, a personal understanding of the unique individuality of the self, and the capacity to make choices within concrete situations involving particular moral judgements (Carper, 1978:22).

These patterns have been extended by Jacobs-Kramer and Chinn (1988). They consider how the knowledge is generated, transmitted and evaluated, through a three dimensional model which consists of the creative, the expressive and the assessment. Jill White (1995), has added the dimension of socio-political knowing to Carper's (1978) original four patterns of knowing. She asserts the need to examine the global context in which nursing takes place, and describes this on two levels

- i) the sociopolitical context of the persons (nurse and patient),
- ii) the sociopolitical context of nursing as a practice profession, including both society's understanding of nursing and nursing's understanding of society (White, 1995:84).

Since nursing has knowledge which has been developed by nurses for nursing, it is argued that nursing is both a discipline and a practice profession (Visintainer, 1986). The preceding discussion raises two issues. First, is it possible to articulate what nursing knowledge is, and second, how has nursing knowledge developed? These matters require further exploration.

Nursing knowledge and nursing practice

As chapter five illustrated, shifts in nursing education corresponded with changes in the beliefs of nurses about what knowledge students of nursing were considered to need in order to practise as a registered nurse. Nursing, for a considerable part of this century, primarily involved the performance of tasks, some of which were the implementation of orders from medical practitioners. Other tasks related to meeting basic needs of patients in terms of hygiene, food or comfort. The knowledge required to do these things was of a concrete nature, learned by imitation, and without any real questioning or critical analysis of underpinning principles or knowledge. The skills nurses had were underpinned by the belief that this is the way things are done.

Proficiency in carrying out these skills, and the knowledge associated with this was acquired through trial and error. What worked in one situation was transferred to another situation. The rules and principles that were part of this were sometimes based on other than trial and error, however. For example, many principles for nursing practice developed from knowledge from other areas that was then applied to nursing. Principles from microbiology in terms of the transmission of microbes meant that procedures such as 'aseptic techniques' for the dressing of wounds and strict routines for bedmaking developed - ostensibly to prevent the transmission of infection.

A further influence in this is that the occupation of nursing had to contend with being seen as an adjunct to medicine where the nurse is perceived as an assistant to the medical practitioner. The knowledge that nurses were considered to need was initially associated with what the nurse could observe and subsequently relay without any interpretation to a medical practitioner. A required characteristic of nurses within the womanly virtue of obedience earlier in this century, was that they

were not to make any inference about what they might think from their observations; their role was to observe and report (Vicinus, 1985). In fact Florence Nightingale insisted that nurses were not to interpret. She enshrined this belief in *Notes on Nursing* (1849/1959), by asserting that accurate observation and accurate reporting was what doctors relied on. Nurses had no mandate to exercise judgement or offer opinion. The duty of the nurse was simply to report what was observed, not to alter or interpret any aspect of information. The place of nurses, in Foucault's terms, was one of surveillance in a limited extension of the doctor's role.

It is not difficult, then, to see why there is a legacy of nursing activity being seen to be associated with not thinking. This was premised on the notion that there was no real knowledge base to the skills of nursing. The emphasis of nursing practice essentially related to ability or skills of how to make someone comfortable and to meet their needs for activities of daily living, such as feeding and bathing that a person may be unable to do themselves because of some underlying health problem or incapacity. Tradition was a significant feature of the acquisition of such skills, and as Ashley (1976) identifies the apprenticeship model of training ensured the perpetuation of traditional ways of nursing care, as student nurses learned by observing experienced practitioners, and through memorizing facts and protocols about the right and the wrong way to undertake various tasks associated with patient care. One of the hallmarks of nursing was the ability to carry out these tasks with speed and efficiency.

Rituals and rational action, which were translated into tasks and routines, formed the basis of nursing practice for many years, and were seen - mostly by nurses themselves - to be the essence of knowledge needed to be a nurse. This perpetuated a particular discourse in itself. Being a 'good' nurse was not only associated with obedience to superiors and authority but also with efficiency in carrying out

particular technical tasks. As tasks became more technical, those which required less technical skill and knowledge of how to perform them with speed and skill, were delegated to others, such as nursing aides, and later to enrolled nurses, and in many situations, to other categories of health workers. Operating from within the security of knowledge from the medical model, registered nurses were able to justify the superiority of their knowledge which had been acquired during their preparation for registration. This knowledge however, represented knowing how to perform a particular task which was learned on the job rather than any formalised process of learning underlying principles related to a particular activity. It became routinised, broken down into series of steps, so that the 'one right way' to do something was often given more attention than the outcome of the activity. Procedure books detailed how specific patient care procedures were to be carried out. But as Beth Rodgers (1991) points out, as a result of rituals and routines in nursing practice, dogma exists in nursing through adherence to authority and tradition, and is a barrier to knowledge development.

Some of these activities undertaken by nurses were referred to as 'delegated medical tasks' - activities which still exist within hospitals in New Zealand. It is considered that such tasks are really the domain of medical practitioners, but since it is nurses who provide care over a twenty-four hour period and not medical practitioners, nurses have been 'taught' how to perform these tasks.²

Nurses, however, have to demonstrate their ability to perform such tasks, and may have a certificate issued to them signed by the senior medical officer of a hospital, such as in the case of the administration of intravenous medications (Dunedin Hospital Nursing Policy and Procedure Manual, 1990). Why this has to happen

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As it will be seen in chapter ten, nurses are accountable for such activities, whether or not they are defined as 'delegated medical tasks'.

possibly says more about the ownership of knowledge than anything else. If competence in the administration of intravenous medications is not required of a beginning practitioner without an additional 'certificate of competence' then it seems to question the necessity for the inclusion of anatomical, and physiological as well as pharmacological knowledge within nursing education curricula, of which students must demonstrate mastery.

Policies such as those for the administration of intravenous medications which require additional credentialling before the registered nurse can undertake a particular activity therefore negate education and reinforce the view that newly registered nurses lack the skills of more experienced registered nurses. Yet as they are unable to perform some technical tasks which come under the realm of 'delegated medical tasks' until they have been certificated to do so, then this suggests such policies may need to be reviewed rather than claiming the nursing education courses are deficient in what they provide. In addition, various courses, in the form of 'inservice education' exist within hospitals to provide opportunities for registered nurses to acquire the knowledge and skills associated with various technical procedures, such as intensive care courses and critical care courses. This was seen to be 'advanced' nursing education. It was the technical skills and tasks, as well as the underlying biomedical knowledge associated with many of these activities, that was for many years, seen to be 'nursing knowledge'. And given the recency of a different emphasis on continuing education, this remains the current knowledge base of many registered nurses in practice in hospitals today.

That this prevailed for so long in nursing can be seen to be linked with what was happening in nursing education. There were limited opportunities for nurses in higher education in New Zealand, as discussed in chapter four. Although there was a school of advanced nursing studies established in 1928, it was not until the 1970s

that any university education was available to nurses. Those who did have advanced nursing knowledge were few in number. Not all nurses in New Zealand working in the area of nursing education when comprehensive nursing education courses were first established during the 1970s had advanced nursing qualifications. Large numbers of nurses in the United States undertook studies in education and applied knowledge from these studies to theorise or think about nursing (Pearson, 1992). New Zealand nurses, however, were able to utilise the information from published literature to apply to nursing education courses, so these courses eventually became influenced by North American ideas about nursing and moved away from the traditional influence of the British nursing it was originally modelled on.

The Nursing Process

During the 1970s a shift occurred in the delivery of nursing care with the introduction of what is known as “the nursing process”. Although this has several definitions, four essential elements are contained within the notion of the nursing process. Yura and Walsh (1973:23) capture the essence of this in their definition, which states that

The nursing process is an orderly, systematic manner of determining the client’s problems, making plans to solve them, initiating the plan or assigning others to implement it, and evaluating the extent to which the plan was effective in resolving the problems identified.

This process can essentially be seen as a problem solving approach to nursing care which involves the elements of assessment, planning, intervention and evaluation. The use of the nursing process by nurses in their practice was also considered to provide an individualised and patient-centred approach to care which would move nursing care away from the task-centred approach which had existed in nursing for many years (Yura and Walsh, 1973). It was seen as a framework for nursing

practice located within a reflective, critical and self-correcting system, which would replace rule bound and principle oriented approaches to nursing care (Chinn and Kramer, 1991). But it was also seen as something with the ability to separate nursing knowledge from medical knowledge. Nurses believed that because it was referred to as the nursing process, it was *nursing* knowledge. In fact it was simply an adaptation of the logical scientific process of linear exploration of a problem and determining solutions to that problem, rather than having any epistemological grounding in the sense of determining how what is known is known, what the rules for knowing are, and the basis for these truth claims (Kelly 1986).

Since the nursing process promulgated a patient-centred and individualised approach to nursing care, there was also a corresponding need for nurses to have a more holistic view of people by which nurses could make a comprehensive assessment of a patient's health care needs or problems. The implications of this approach were that nursing education programmes would need to contain knowledge about psychological and social factors which were part of the composition of an individual was included within nursing curricula. Many nurses believed that use of the nursing process was a significant shift in the way that nursing knowledge was now used to provide comprehensive nursing care based on more than the physical needs of individuals as was the case in early nursing education courses.

Since the nursing process needed to be based on some sort of framework of knowledge about people from an holistic perspective, this meant that such a framework needed to be developed. If patients had particular health problems, the basis for these problems had to be able to be identified. Many schools of nursing in New Zealand used Abraham Maslow's (1970) hierarchy of human needs in this regard simply because they knew of no other conceptual framework.

It could be said that the nursing process influenced nurses and nursing from two different perspectives. On the one hand it utilised a reductionist approach to nursing care. It placed patients under the normalising gaze of nurses, and in doing so reduced their health care needs to a set of problems about which nurses made judgements and measurements, made diagnoses and implemented interventions based on the assessments they had made. Written nursing care plans were seen as a way of documenting the individual care needs for patients and communicating to others what nursing care was planned for a particular individual, and what nursing care had been given. On the other hand, the nursing process was a way of making nursing care more visible than the unspoken and undocumented care that had been part of the nursing ethos for many years. But what it also did was to place nursing firmly into a discourse of diagnosis. By emulating the principles of medicine's diagnostic function, nurses became trapped in the myth of "scientific supremacy" (Chinn, 1985) in an attempt to establish a base of nursing knowledge.

Nursing diagnosis

From within the stages of the nursing process, nurses developed "the nursing diagnosis". Kim (1994) identifies that this is a product of North American nurses which emerged in 1973 as an attempt to provide a way of thinking about and defining nursing. Nurses using this approach are required to organise their thinking around problems that patients may experience, to ensure a common language for communicating among and between nurses and other health professionals. But perhaps more importantly it grew out of a concern by nurses to be seen to have an "... identifiable and unique set of professional services to offer". Nursing diagnosis is seen to be a way of defining what nurses do that unqualified health care workers are not able to do through the use of judgement as suggested in the way it is defined as "... a clinical judgment about individual, family, or community responses to

actual or potential health problems/life processes ... (which) ... provide the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable” (Fitzpatrick, 1991:25).

While the essence of this definition seems to be concerned with the matter of clinical judgement, nursing diagnosis is actually a classification system in much the same way that the medical profession classifies diseases. Each “nursing diagnosis” has three highly structured components “(1) the problem statement or nursing diagnosis label plus definition; (2) the etiology or related factors; and (3) the signs and symptoms or defining characteristics” (Kim, 1994:216). It is difficult to see where the clinical judgment of the nurse enters into use of the nursing diagnosis classification system, since it operates essentially as a checklist. To explore this a little further it is helpful to analyse each of the components of a nursing diagnosis. Within the component of signs and symptoms or defining characteristics, the nurse assesses what problem the person manifests. Interventions (or treatment) are based on what has been identified and what “fits” within a particular taxonomy of a specific nursing diagnosis. Its highly structured system of classification therefore makes it very reductionist, since all human responses are stated to come within these particular groupings. It is, despite being called *nursing* diagnosis, predicated on the biomedical model which espouses cause, effect and treatment.

In Foucauldian terms, what utilisation of a system of nursing diagnoses does, is to ‘normalise’ the patient. Surveillance of signs and symptoms, combined with normalising judgements, fit people into various forms of subjectivity. The norms of a specific nursing diagnosis are imposed by the nurse on the patient. These practices therefore constitute forms of disciplinary technology (Foucault, 1984). In addition, the use of the nursing diagnosis privileges outcomes, in the sense of linear progression toward some predetermined goal, rather than identifying the difference

the work of the nurse might contribute towards the patient. It emphasises nursing procedure at the expense of critical thinking or conceptual grounding in nursing knowledge. It subjugates the nursing knowledges nurses might have about what it is that is the essence of nursing care.

Nurses have been reluctant to relinquish the knowledge of the medical model. Understandably so, perhaps. To do so means

leaving or giving up a place that is safe, that is “home” - physically, emotionally, linguistically, epistemologically - for another place that is unknown and risky, that is not only emotionally but conceptually other; a place of discourse from which speaking and thinking are at best tentative, uncertain, unguaranteed (de Lauretis, 1987:138).

Despite, however, the reliance of nurses on other forms of knowledge (and by this is meant utilisation of knowledge from the biomedical model), nurses have been involved in developing nursing knowledge. The next part of this chapter will explore this in more detail.

Structuring nursing knowledge

The establishment of knowledge distinct to nursing can be seen to do what Jane Flax (1993:xi) puts so clearly when she says

One of the still powerful hopes of the enlightenment is that knowledge could serve as a simultaneously neutral and beneficial force. It will empower us to act rationally and in so acting we could perfect humans and their institutions. Reason, truth, knowledge and power interact to generate and therefore legitimate authority. Such authority reflects and ensures our freedom; in obeying we confirm our sovereignty and escape from domination” (Flax, 1993:xi).

This is no different for those nurses who have sought to develop nursing knowledge. But in the construction of nursing knowledge, nurses seem to have been somewhat preoccupied with attempting to define what nursing actually is. One

of the aims of scholarly writings by nurses entering the realm of epistemology in nursing, for example, has clearly been to define nursing. As Taylor (1994) identifies, since there is no consensus by nurses about an agreed definition of nursing, this possibly reflects the diversity of nurses in their experiences of nursing. One difficulty in attempts to determine what nursing *is* could be associated with what it is that nurses *do*, in that the title of nurse as the practitioner is also the verb for the other. As Judy Lumby (1991:17) points out, what nurses do is 'nurse'. This is not the case for other health practitioners where other verbs are used to describe their practice, for example surgeons operate; doctors practise medicine.

Mary Blegen and Toni Tripp-Reimer (1994:88) identify that conceptualisations of nursing which began to appear in the literature in the mid-twentieth century were "...statements devised in large part, for the purpose of delineating a separate professional identity from medicine". They reflected both a need to identify what nursing was and a need to determine what was unique in nursing. During the 1970s this was also associated with efforts by nurses to determine the nature of nursing as a discipline (Donaldson and Crowley, 1978). American nurse theorists attempted to move nursing away from its focus on disease, skills and procedures towards an approach which considered the person in terms of their psycho-social makeup in an effort to define nursing (Peplau, 1952; Orlando, 1961). Others were concerned to ensure that the comprehensive nature of the person and their relationship to the environment in terms of health and nursing was transferred into a theoretical view (Roy, 1970; Rogers, 1970; King, 1981). Some of the early definitions of nursing provide some insight into this interrelationship. Peplau (1952:16) suggested nursing was "... a significant, therapeutic, interpersonal process". Henderson (1966:1) defines nursing as "... assisting the individual, (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary

strength, will or knowledge". It is interesting to note within these many and varied definitions that what is stated is that nursing 'is'. Beth Rodgers (1991) argues that this represents the philosophical viewpoint of essentialism, in which it is seen to be appropriate to make statements about the 'truth'. More recently, American nurses such as Jean Watson (1985) and Madeleine Leininger (1989) have begun to define nursing in terms of its caring role. The discourse of caring will be further explored in chapter eleven.

That there is a critical relationship between practical and theoretical knowledge and nursing knowledge has been identified by nurse scholars. Bottorff and D'Cruz (1985:14) contend that knowledge is a social product as it is

socially generated, shaped, reviewed and revised: nursing knowledge is developed not simply by attendant professionals, such as nurses, but also by the waves of patients whose existence has made necessary and possible and ensured a profession called nursing.

What is proposed in any social constructionist viewpoint is that nursing knowledge has developed out of the experience of nurse-patient interactions - the experience of nursing, and the development of knowledge from nursing practice. This knowledge, however, it seems, is valued less than the knowledge associated with medicine.

The discourse of medical knowledge

Foucault (1973), in *The Birth of the Clinic*, identifies how the 'clinical gaze' enabled medical men to define reality and obtain social prestige and influence. As a result, scientific medicine and technology, although an amalgam of science and ideology, is privileged in the health care system since it promotes a model of illness and cure that society has come to expect as a right (Willis, 1989). This hegemony

accords the medical profession control of the health system and this control is legitimated by the ideology of professionalism, which itself is a specific form of the ideology of expertise (Willis, 1989:204).³ The discourse of medicine is aligned with the discourse of 'scientific' knowledge in the form of positivism. This discourse is dominant in the production of 'acceptable' knowledge, so it is important to examine what it means, and what its assumptions are.

Positivism and empiricism

According to Flew (1984), the term positivism was first used in the nineteenth century by Auguste Comte (1798-1857), based on a tradition starting with Hume, Bacon and Locke. Comte proposed a 'positive' philosophy, the fundamental tenets of which were that only data which were obtained by experiment and objective observation, could be considered as 'positive' truth. According to Meleis (1985), from the 1920s to the 1960s, philosophy of science has been dominated by what has become known as 'logical positivism', and which was later referred to as 'logical empiricism'. From this, the 'received view' or the 'scientific method' emerged. This means that that the focus of this view is the justification of discovery through amalgamating logic with the goals of empiricism, in order to determine the truth about the world.

Although as Giddens (1974:i) points out, positivism has "... lost any claim to an accepted and standard meaning", it has been the dominant discourse for the development of 'scientific' knowledge. It is helpful, therefore, to examine its assumptions. These have been summarised by Usher (1996) as follows:

- The world consists of phenomena which are lawful and orderly. Thus it is

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The discourse(s) of professionalism will be discussed in chapter ten.

'objective' in that it exists independently of knowers. The use of systematic observation and 'scientific' methods, that is 'being objective', makes it possible to discover this lawful world. Hence, phenomena and events can be explained, predicted, and controlled.

- Subjects and objects can be clearly separated or distinguished, as can the 'subjective knower' and the 'objective' world. A clear distinction is also assumed to exist between facts (the domain of the 'objective') and values (the domain of the 'subjective').
- The validity of knowledge claims is determined according to whether these are based on use of the senses, such as observation, which is augmented by measurement. Since data are considered to be the same, exposure of different observers to the same data means that observers should be able to come to the same conclusion.
- The social world and the natural world are alike. Order and reason in the social world means social life is patterned. There is a cause and effect focus to this pattern, thus things do not occur arbitrarily and randomly. Thus general and universal laws that explain the world can be developed.

While the hegemonic position of medicine in terms of empirical scientific or positivist knowledge may have had dominance in the health system, it is disputed whether this can continue unimpeded as new forms of knowledge gain legitimacy in society. Figilo (1977:265) challenges the positivistic methodological basis on which medicine bases its assumptions for 'progress' of medical knowledge when he says

the concrete record of scientific and medical development assumes without question that there are solid facts to discover and that the continual discovery of these facts lead eventually to the state of knowledge that we have today. But this very assumption automatically isolates the endeavour called 'scientific' or 'medical' advancement from its social context. That is, it neither examines the non-intellectual contingencies which mould ideas, nor does it look at the use of scientific or medical concepts as cultural, social, religious or ideological tools. By their very definition facts could never carry this kind of load ... the solid record of the history of medicine, with its cautious abstinence from interpretation or evaluation, is deceptive, because it reinforces in an implicit and unimpeachable way the currently held views of medicine and does this in the name of 'historical perspective'.

In essence, this quotation highlights the fallibility of use of positivism to provide a comprehensive view of the world. The rigorous scientific rules developed by positivism cannot address all aspects of reality. If this was so, positivism would be able to determine all that is to be known. Foucault (1977:45) claims that the positivist position on knowledge assumes "... an eye whose entire substance is nothing but the transparency of its vision".

Nonetheless, the alignment of medicine with positivism has meant that the knowledge of medical practitioners is considered to be of greater value than the knowledge that nurses may have, as the next part of this chapter will illustrate.

Gender, knowledge, nurses and stereotypes

Alice Baumgart (1985) highlights expectations society has about what knowledge nurses have when she refers to an inquiry into infant deaths from cardiac arrest in a hospital for sick children in Toronto, Canada. In this inquiry, lawyers, who were mostly men, asked doctors, who were mostly men, what they *knew*. When the same lawyers questioned the nurses, what was asked was in relation to their experience, not what they knew. This illustrates for Baumgart (1985:21-22) that "Experience in our society is considered second class compared to knowledge.

Nurses should not know". She concludes from this that "In the health care system, doctors have been regarded as the only 'rightful knowers'. What the doctor-nurse game is really all about is that nurses know, but can't let the world know that they know" (Baumgart, 1985:21).

Lorraine Code (1991) identifies that the position of women in an epistemic community is influenced by stereotypes about women. She identifies two structural patterns which combine to contain women within particular cognitive domains, and impedes their efforts for acceptance as authoritative members of epistemic communities. The first of these is the stereotypical view of women as illogical, emotional individuals who are incapable of any abstract intellectual thought. Since in this view the judgement of women is seen to be influenced by unpredictable subjectivity, minimal credence is accorded to women's claims to knowledge. Second, is the distinction that is made between knowledge and experience, as in the situation illustrated by Baumgart (1985). The stereotypical view of women described above excludes women from constructing knowledge and only gives them access to experience. Most importantly, however, knowledge is valued; experience is not.

The women - intensive occupation of nurses is no exception to the stereotyping. As discussed in chapter four, the biological determinism apparent in the early days of nursing in New Zealand where 'every woman was a nurse' has left nursing with a heritage that the knowledge needed to be a nurse is innate to the qualities of women.

Ways of knowing

There has been recognition of differences in the ways that men and women develop frameworks for organising knowledge. Perry (1970) identifies four positions by which men make sense of their educational experiences, which occur in a linear

sequence. Each position is an advance over the other, and have been summarised by Leddy and Pepper, (1993:98) as consisting of:

1. Basic dualism: Authorities hand down the truth, and the learner is passive. Choices are perceived as either right or wrong, black or white, good or bad, we or they.
2. Multiplicity: The teacher may not have the right answer. A personal opinion is acceptable and may be valid.
3. Relative subordinate position: Evidence is sought for opinions. The emphasis is on analysis and evaluation of information.
4. Full relativism: Truth is relative. The meaning of knowledge depends on its context.

In a study of the perceptions of women, Belenky, Gollberger and Tarule (1986) identified five patterns of women's ways of knowing: silence, received knowledge, subjective knowledge, procedural knowledge and constructed knowledge. Although it is not clear whether these patterns develop sequentially, they are summarised to highlight an apparently different pattern from Perry's four positions.

- Silence: the perception of being voiceless leads to an acceptance of the voice of authority for direction.
- Received knowledge: the perception of being voiceless leads to the individual receiving and reproducing knowledge from an all-knowing external authority. However, the individual does not consider that knowledge can be created by her own ability.
- Subjective knowledge: personal intuition and subjective knowledge are experienced; truth and knowledge are personal, and difficult to articulate.

- Procedural knowledge: this comes from structured procedures and systematic analyses. Objectivity is used by the knower as a measure of what can be known.
- Constructed knowledge: Knowledge comes from both subjective and objective strategies of knowing. Different ways of knowing are integrated, and all knowledge is constructed. The knower and the known are integrated, and the individual experiences herself as a creator of knowledge.

It can be argued that the location of nursing within the discourses of gender, (given that nursing is a women-intensive occupation) and medicine has inhibited the development of constructed knowledge and emphasised received knowledge.⁴

Approaches to the generation of nursing knowledge

During the 1970s, as identified earlier, nurses exercised agency and became involved in the development of nursing knowledge, much of which was designed to create a body of knowledge that would emphasise the uniqueness of nursing as a profession. In order to do this, nurses used the assumptions of empiricism, in which the patient was viewed as a set of systems, to be manipulated by the activities undertaken by the nurse. The work of some of the early nursing 'theorists' from North America can be seen to be an example (Henderson, 1966; Roy, 1970; Orem, 1981).

⁴ The writer speaks here from personal experience, as well as the experience of teaching in courses where registered nurses are undertaking the requirements for an undergraduate degree. The first pattern of Belenky et al's (1986) way of knowing - silence - is evident when these nurses first embark on the course. Later, constructed knowledge is apparent when these nurses create knowledge from their own practice experiences.

Meleis (1985) notes that this approach has been used by many nurses in an endeavour to reduce and quantify aspects of nursing that simply cannot be reduced and quantified. She claims that nursing is still influenced by this approach to knowledge development. In this regard, her views are supported by others who criticise nursing for continuing to rely on inappropriate and outdated epistemological notions (Allen, 1985; Thompson, 1985; Allen, Benner and Deikermann, 1986; Holter, 1988). These authors suggest that there are other ways of generating knowledge for nursing, such as the interpretive and critical paradigms. To elaborate further on what is meant by these paradigms, it is helpful to consider them through the work of Jurgen Habermas in relation to what he describes as “knowledge-constitutive interests” (Habermas, 1971).

Habermas (1971) contends that specific viewpoints by which people view the world represent three categories. These are identified as technical, practical and emancipatory interests, which are seen as distinct, but interrelated domains of knowledge. According to Habermas (1971:308), these are “... based on three distinctive clusters of sciences: the empirical-analytic sciences, the historical-hermeneutic sciences, and the critically oriented sciences”. These three clusters of science provide an “... orientation toward technical control, toward mutual understanding in the conduct of life, and toward emancipation from seemingly ‘natural’ constraint” (Habermas, 1971:311). What is important about the work of Habermas is that it sets out clearly that each of these different domains generates different knowledge. In the empirical-analytic domain, the knowledge produced is associated with the development of technical interests. The historical-hermeneutic domain produces knowledges which constitutes practical understandings of meaning, and relates to social existence. The critical domain aims to bring about self-knowledge and self-reflection, and in this regard has an emancipatory intent in that it will “... release the individual from the constraint of domination and

distorted communication by creating knowledge which furthers autonomy and responsibility” (Habermas, 1971:197).

While this brief summary of Habermas’ knowledge-constitutive interests does not do justice to his work, it does provide an introduction to different ways of viewing ways in which to structure nursing knowledge. Most significantly, it draws attention to the notion of critical theory, which has begun to influence nursing knowledge and nursing education in New Zealand. It is time to return to the scene of nursing education in New Zealand in the 1990s to explore how this has happened.

CHAPTER EIGHT

TRANSFORMING NURSES BY DEGREES

A new configuration of nursing education in the form of undergraduate degrees within which individuals were also prepared for registration as comprehensive nurses began in three polytechnics in New Zealand in 1992. Foucault's notion of governmentality becomes apparent here in terms of the role of the State in the creation of this different nursing identity, who was to be subjected to further processes of normalisation, in that another organisation became involved in the surveillance and measurement of individuals seeking to become registered nurses. In order to provide an undergraduate degree programme, as well as one which met standards for registration, the requirements of two separate statutory controlling authorities now had to be met. First the requirements of the Nursing Council of New Zealand under the Nurses Act 1977 in terms of curriculum approval for registration standards, and second, the accreditation requirements of the New Zealand Qualifications Authority (NZQA). The latter organisation, established under the Education Amendment Act 1990 as a result of reforms within education, signalled its intent to develop a qualifications framework based on sets of vocational and academic standards to which all qualifications were planned to be linked (New Zealand Qualifications Authority, 1991).

These changes to nursing education and the creation of a framework of qualifications were to have a significant influence on nursing. Some of the tensions relating to the transfer of nursing education from hospitals into polytechnics, which had been only superficially buried, were resurrected. In the main these tensions can be said to relate to differing views of what nursing education programmes should do in producing practitioners for the health care system in New Zealand, and

illustrate different perceptions of how a nurse should be prepared for practice. But there were also tensions among the nursing profession, and a shift of emphasis to employment issues rather than on the potential for an educated nurse with an undergraduate degree. The interrelationship between power and knowledge becomes evident in this chapter, which explores the consequences of establishing undergraduate degrees in nursing education, primarily utilising the historical axis of the framework for this thesis.

This chapter, therefore provides an overview of socio-political issues associated with a shift of direction in terms of different way of preparing nurses for registration. In addition, the notion of “curriculum revolution” which espouses a different way of organising curricula used in nursing education is explored and critiqued in relation to its potential and actual significance for nursing education in New Zealand. These issues are considered in relation to different perceptions of and expectations about the nursing identity.

Educational Reforms

During the 1980s, but particularly with the election of a Labour Government in 1984, New Zealand was set on a path of what might be considered as a radical shift in thinking about the economic order of New Zealand. Within this radical revisioning of the state, the education system, along with others, began to be “reformed”. This provided an opportunity for nursing education, located within the polytechnics that may not have been anticipated.

In July 1988 the *Report of the Working Group on Post Compulsory Education and Training* was published. This report essentially endorsed the framework of an

earlier report on educational reform in New Zealand -*The Picot Report*.¹ During 1989 two documents were published which outlined the Labour Government's policy for post-compulsory education and training in New Zealand.² Within *Learning for Life Two* the policy directions for the role of polytechnics are outlined.

Of importance in these policy directions is what has been termed "the new cult of efficiency" (Bates, 1990), the functions of the Department of Education were decentralised, and it was reshaped into a policy producing Ministry of Education and polytechnics were to have a new "freedom" of institutional autonomy. Most significantly, for those polytechnics within which comprehensive nursing courses were situated, they were to have

Broad objectives, reflecting their role in post-school education and training ... To satisfy these broad objectives, polytechnics will be able to offer courses at degree level, provided that the standards of the National Education Qualifications Authority³ are met. Polytechnics will not be accredited as degree-awarding institutions on the same basis as universities. Instead they may apply to have any degree-level courses they offer on a course-by-course basis (Department of Education, 1989b:5).

The enactment of the Education Amendment Act 1990 empowered polytechnics to confer degrees. This set nursing on a trajectory that created dissension and debate between nurses. It is arguable whether at the time nursing education courses were first located within the tertiary education system, it was envisaged that some twenty years nurses would be prepared for registration within the structure of an

1 *The Picot Report - Administering for Excellence* (1988) essentially targetted primary and secondary education sectors, but nonetheless provided a framework for reform throughout all sectors of education in New Zealand.

2 These reports are *Learning for Life: Education and Training Beyond the Age of Fifteen*, which was published in February 1989, and *Learning for Life Two: Policy Directions*, published in August 1989.

3 This later became the New Zealand Qualifications Authority.

undergraduate degree. The idea of degrees within polytechnics, however, was not new. In 1981, the Director-General of Education at that time, W L Renwick, had suggested that there were equity issues in terms of similar standards for non-university diplomas and university courses leading to degrees. He challenged whether the differences in status could be justified, and argued that various debates over the last twenty years had concluded that there was no justification for distinctions to be made between a diploma and degree where the course duration and standards were similar.

Renwick's comments about equity are even more meaningful when considering the limited opportunities in New Zealand for nurses to undertake nursing studies at degree level. As previously discussed, (refer to Chapter four), nursing had campaigned to have nursing education located within the university system. Prior to the enactment of the Education Amendment Act 1990 which followed from the Government's *Learning for Life* policy directions, higher education in the sense of degree level programmes which were specific to nurses was only available at two universities in New Zealand. Massey University and Victoria University⁴ began offering nursing studies courses within a Bachelor of Arts degree in 1973. To be enrolled in either of these programmes, however, individuals had to be registered nurses. This meant that for nurses to complete an undergraduate degree, this was additional to the three year nursing education course that had already been completed to obtain registration as a nurse. To undertake an additional three years of full time study in order to obtain an undergraduate degree not only negates the value of the first course of study, but also raises the issue of equity. As Margaret Horsburgh (1991:27) puts it "... that preparation at degree level is only appropriate

⁴ The Victoria University nursing degree programme which originally commenced in 1973 was under threat throughout its history. A review in 1990 led to a proposal for a postgraduate nursing degree programme which was established in 1993. Undergraduate degree in nursing studies are no longer offered through this university.

once a nurse has completed a rigorous three-year programme of study is completely inequitable”.

Horsburgh's statement was written in support of the ability of polytechnics to confer degrees. This view was not, however, necessarily shared by everyone, and opened up debate about issues of offering undergraduate degrees in polytechnics. The perspective of Norma Chick (1991:11) was to emphasise that the establishment of undergraduate degrees in polytechnics would not be the solution to the problems of nursing education. Warren Young (1991) identifies that university qualifications were the exception for nurses in New Zealand, and that in 1989 out of a total of 623 nurse tutors teaching in polytechnics, only 19% had a Bachelors' degree and 1.5% had a Masters degree. Young attributes this both to an apparent lack of conviction among the nursing profession in New Zealand of the value of university education for nurses as well as obstacles within the workplace which may thwart nurses in an attempt to undertake university courses. More to the point, perhaps, this illustrates the lack of availability of university courses to nurses unless they either lived in one of the cities of New Zealand in which there is a university, or undertook extra-mural studies through the one university - Massey - which offered university courses in this way. A further, but somewhat prohibitive option, was to relocate for the duration of a course of study leading to a university qualification, ⁵ since the seven universities in New Zealand are based in the larger cities of Auckland, Hamilton, Palmerston North, Wellington, Christchurch ⁶ and Dunedin.

⁵ It is important to note that despite the barriers to university education in the area of nursing studies, many nurses in New Zealand found ways of overcoming these, and are graduates of Massey or Victoria Universities. Since there is presently no statistical date on such graduates, the actual numbers remain unknown.

⁶ Lincoln University in Christchurch, it must be noted, provides courses which are primarily concerned with rural activities, such as farming and the environment. It would be unlikely that nurses would undertake a university course at this particular university to obtain a qualification appropriate to nursing activities.

Despite the NZQA requirement (refer to appendix three) for polytechnics to consult with the wider community, which it must be said would also include nurses, before a degree could be considered, there was dissension among nurses about the establishment of undergraduate nursing degrees in polytechnics. One of the areas of disagreement was in relation to whether these degrees should be three years or four years in length. As Judith Christensen (1993) points out, there had been little, if any, debate about the length of undergraduate degree programmes in nursing. In the event, two polytechnics commenced four year programmes. They did so on the basis that students could complete the requirements of the Nursing Council of New Zealand for registration in three years, and the fourth year would meet the requirements of the NZQA. Indeed it was believed that it was not possible for both the requirements of an undergraduate degree as well as the requirements for registration to be achieved in three years (Wellington Polytechnic, 1991).

The Ministry of Education made it clear, however, that funding would only be provided for a three year degree programme. All three programmes subsequently became three year degrees. In order to this this a reconfigured organisation of the undergraduate degree was required to be submitted to the NZQA by two of the polytechnics. As the requirements of the Nursing Council of New Zealand for registration made no distinction between a diploma level course and a degree level course, changing curricula was not an issue, as long as the requirements for registration could be met within three years, according to the provisions of the Nurses Act 1977. What had to be changed was the inclusion of the research component of the degree so that it was incorporated within the specified three years (Personal communication, Judy Kilpatrick, 1996)

It is the research component of an undergraduate degree that the Education Amendment Act and the New Zealand Qualifications Authority (NZQA) emphasise

in differentiating between a degree and a diploma. The NZQA definition of a degree is that it is

A course of advanced learning that is taught mainly by people engaged in research and which emphasises general principles and basic knowledge as the basis for self-directed work and learning. Such courses provide students with a systematic introduction to a coherent body of knowledge, its underlying principles and concepts, associated usages and applications, and analytic and problem-solving techniques. Students develop the academic skills and attitudes needed to comprehend and evaluate new information, concepts and evidence from a range of sources, so that after completion they can continue to review, consolidate, extend and apply the knowledge gained in their degree studies. A course usually includes the provision of major studies in which a significant literature is available, course content is taken to a significant depth and knowledge is progressively developed to a level which provides a basis for postgraduate study (NZQA, 1990).

Despite the belief of some nurses that the diploma offered for comprehensive nursing courses could simply be translated into a degree with some additions and/or alterations, it is clear that there is a difference between these two educational credentials. The emphasis on the importance of research within a degree is clearly apparent.

The real challenge for nurse educators, however, was to develop a curriculum that reflected the degree requirements of the NZQA and the registration requirements of the Nursing Council of New Zealand. For most this also meant ensuring that staff teaching within the programmes were appropriately qualified to do so. Given the paucity of nurses with postgraduate degrees - and actively engaged in research in part from difficulties accessing higher education, and in part from an ethos in nursing which emphasised the acquisition of clinically focussed post-basic education in the form of Advanced Diplomas in Nursing undertaken in polytechnics - the arguments about academic credentials (Chick, 1991; Young, 1991) can be considered to be pertinent.

Assumptions for change in nursing education

The shift of nursing education from the hospital based apprenticeship model to its location in polytechnics was predicated on the belief that it was appropriate to have a different nurse (Kinross, 1984; Perry, 1985). It is helpful to examine the assumptions and driving forces associated with this second shift in thinking about nursing education. It was identified in chapters four and five that the system of nursing education which had prevailed for some seventy years, relatively unaltered, was fraught with various problems. Essentially these were concerned with two areas - the narrowness of nursing education in terms of meeting the needs of a comprehensive health service, and problems associated with nursing education programmes, which included high attrition rates of students and difficulties in recruiting appropriately qualified teaching staff (Department of Health, 1988). The evaluation of the comprehensive nursing courses published in 1981 (Taylor et al, 1981) concluded that the courses met the expectations of the original intention of preparing a practitioner to practise as a registered nurse in a variety of health care environments. This was reinforced by the Review of the Preparation and Initial Employment of Nurses workshop in 1986 which addressed concerns about the comprehensive nursing courses and their graduates although, as earlier identified, there were some issues that were of concern, particularly in relation to orientation programmes for new graduates.

The present health care environment, with an emphasis on consumer rights, self responsibility in promoting and maintaining health, as well as recognition that hospitalisation in a sense, reactive, has reinforced a view that there are ways of achieving positive health outcomes other than expensive secondary care services. In addition, technological changes have led to alterations in the medical treatment of individuals, resulting in shorter hospital stays and recuperation at home. This means that there is a corresponding need for a nurse who is able to function in a

broader role than the hospital environment, and this seems almost more crucial than it was when change to the system of nursing education was first mooted around twenty-five years or so ago. Bevis and Krulick (1991:362) sum this up succinctly in saying

The changing needs of society, the increased technological mechanization of health care, and the increased knowledge of the public about the kind of care it needs and desires have combined to persuade nurses in many parts of the world that they must graduate as a more knowledgeable, creative, autonomous, compassionate scholar-clinician for modern society.

For a variety of reasons, not least of which is limited opportunities to higher education, nursing in New Zealand has been slow to recognise the value of scholarliness. If anything, there is a prevailing view that a 'real' nurse works in clinical practice and there is a residual ethos that the process of becoming a nurse is not about intellectual activity but about exposure to quantities of clinical experience. The ethos of 'learning by doing' is particularly evident in the emergence of Advanced Diplomas in nursing at four polytechnics during the 1980s - a qualification initially proposed by the New Zealand Nurses Association in its publication "post basic qualifications for nurses" and reinforced in 1984 through the notion of a career path for nurses in which the advanced diploma of nursing was an essential feature for nurses in clinical areas to advance both in terms of a career path and in terms of advancing nursing knowledge. University preparation was seen to be necessary only for a small number of nurses, a view which perpetuated views predominant prior to the Carpenter report of 1971.

During 1990, concern was increasingly expressed from various groups with an interest in nursing and nursing education about the effects of restructuring of the health and education sectors and the lack of any national framework for nursing and midwifery education. At a meeting held in Wellington in September 1990 at the

New Zealand Nurses Association annual conference, a group of nurses from various organisations set up a committee to develop a national framework for nursing and midwifery education with targets, guidelines and strategies to establish shared ownership of education targets (Vision 2000, 1991). A national forum was organised where debate about this could take place. A significant part of the discussion and background focus for this forum was the impact of the Education Amendment Act 1990, that is the ability of polytechnics to offer undergraduate degrees as part of the educational process of becoming a registered nurse, which some heads of schools of nursing had signalled an intention to do. Participants and speakers at the forum discussed the role of nursing education and the outcome of nursing education programmes as well as the need to ensure that nursing had a vision for the future of nursing education. A committee, seen to be representative of nursing stakeholder groups was established, and charged with the responsibility of analysing and reporting the outcomes of the forum. Three themes emerged from the forum. Firstly, concern about current conditions in health and education and the impact of these on nursing and midwifery education, secondly, the need for wide debate and communication between and among nursing and other groups, and thirdly, a mandate for the development of a national framework for nursing and midwifery education (Vision 2000, 1991).

Eventually a discussion paper was produced which proposed such a framework for nursing and midwifery education in New Zealand (Allan, 1992). This was circulated to individuals and stakeholders in New Zealand in January 1992 in order for submissions to be made by March 1992 (Vision 2000 Committee, 1992). But it was doomed to failure. Some of the recommendations were considered untenable. In particular, there was a recommendation that the roll should be closed which would effectively mean the demise of enrolled nurses. The ongoing debate about enrolled nurses will be investigated in chapter ten, but it needs to be noted here that

the inclusion of recommendations about the future of enrolled nurses in the paper arising from the Vision 2000 forum probably effectively negated every other proposal for a national framework. The New Zealand Nurses Association disassociated itself from the discussion paper and its recommendations (New Zealand Nurses Association, 1992). A further recommendation of the proposed framework was the establishment of a four year degree as the sole criterion for entry to practice. The New Zealand Nurses Association (1992:23) opposed this recommendation on the grounds that

it presupposes abolition of second-level nurse preparation; also, four year training is unrealistic, given the needs of prospective nurses and midwives. A three-year degree is suggested.

Following the analysis of “a large number of submissions”, a framework for nursing and midwifery education (refer to Appendix four) was published in December 1992 (Vision 2000 Committee, 1992). One of its suggestions was for the formation of a national group to provide ongoing direction and action for nursing and midwifery education. That has never happened. Despite an expression of concern from the New Zealand Nurses Association about the lack of a national framework for nursing education, it appears its vision was selective. The establishment of undergraduate degrees in all polytechnics with comprehensive nursing courses has now occurred, despite any real attention being paid to the framework for nursing and midwifery education arising from the 1991 Vision 2000 forum, and without any real oversight by any national nursing group.

In essence nursing education was, then, in a position where there was a framework, not accepted by all stakeholder groups in nursing, and therefore, without an accepted vision. Given that the expressed goal of the Vision 2000 forum envisaged by the nurses from stakeholder groups who organised this forum was to “... develop a national framework for nursing and midwifery education with

targets, guidelines and strategies to establish shared ownership of education targets” (Vision 2000, 1991), if one was to speculate, the real agenda may have been one of reducing the intakes of individuals into comprehensive nursing courses.

Too many nurses?

The proposals to establish degrees in nursing departments of polytechnics provided a catalyst for discussion about the nursing education system in general in which issues were raised that had been simmering as a result of ‘reform’ of the health system. Many of the arguments that had arisen before and during the transfer of nursing education into the polytechnic sector emerged again as the need for all nurses to undertake nursing education at this level was questioned. Some of the challenges concerning the appropriateness of undergraduate nursing degrees came from within nursing; in particular from some nurse educators and from the New Zealand Nurses Association. That this organisation expressed reservations in the wholesale adoption of undergraduate degrees is in itself a point to be noted, since it had previously championed the transfer of nursing education from hospitals into the tertiary education sector, and members of its predecessor - the Trained Nurses Association - were said to have vociferously supported university education for nurses during the 1920s (Hughes, 1978b).

The debate about the establishment of undergraduate degrees in polytechnic schools of nursing seems to be centred around three main areas. First, whether all future nurses should have an undergraduate degree, or whether the diploma should continue to be offered as an option. Second, whether the length of the degree course should be three years or four years. And finally, whether the staff within the polytechnics were appropriately qualified to teach at undergraduate degree level. Underpinning all this was a concern that no real debate had occurred to address these matters (Horsburgh, 1991; Chick, 1991, Cottingham, 1991). The

Vision 2000 forum provided an environment for at least some debate to occur in relation to this, but it was given little attention.

Issues for the New Zealand Nurses Association in relation to nursing education were associated with the the lack of a national policy on nursing education, and of paramount importance for this organisation was a need to determine both the nature and number of nursing education courses needed to prepare nurses for the future health care system. In particular, concerns related to the number of comprehensive programmes necessary to meet nursing workforce requirements, how quality learning could be assured when quality clinical experience appeared to be decreasing, and whether comprehensive nursing education should consist of diploma programmes, degree programmes or a mixture of both. Other concerns expressed relate more broadly to perceived implications of changes to nursing education for nurses and nursing, such as the place and preparation of the enrolled nurse, the relationship between qualified and unqualified staff and maintaining professional standards of nursing practice and education (Williams, 1991). In addition, the relationship between nurses working in the health and education systems seems to be a significant concern for the New Zealand Nurses Association. Williams (1991:13) points out: "If we allow the needs of education providers alone to drive nursing education, then nursing will have failed the public and defaulted on its social contract".

What is being alluded to here is the number of students being taken into nursing education courses and a corresponding perception that there were insufficient positions for new graduates on registration. Williams (1991) notes two key points in relation to the number of graduates ready to enter the nursing workforce. Firstly, not all graduates had been able to obtain work as nurses following registration, but that 50% of new graduates over the last two years had obtained nursing

graduates from some polytechnic courses went overseas to obtain work as a nurse without ever working as a nurse in New Zealand. This, it is claimed, is wasteful of resources and a source of frustration and anger to those nurses who in making personal sacrifices to complete their nursing course find no positions available to them upon registration.

It is useful to briefly examine the number of nurses who did actually leave New Zealand for work overseas. However, it is difficult to determine the actual number of new graduates who did this, since there is no clear data to identify the numbers of new graduates and their corresponding employment in an overseas country. However, an analysis of the annual reports of the Nursing Council of New Zealand for 1989-1991 provides some interesting information. William's (1991) claim that for two years large numbers of comprehensive graduates were going to the United States of America in particular was presumably for the two years 1989-1990, since this assertion was made in November 1991 at which time a group of some 1311 students had yet to undertake their registering examinations. The Nursing Council of New Zealand, as the registering authority for nurses and midwives provides verification of transcripts for nurses seeking employment as a nurse in other countries. Its figures show that for the year 1 April 1988 to 31 March 1989, there were 986 nurses requesting verification of their New Zealand qualification for overseas registering authorities. A total of 477 of these nurses had comprehensive registration, and 463 of these nurses had registered since 1987. Of the total of 986, the majority of nurses (581) sought verification for employment in the United Kingdom, followed by Australia (271), Canada (79) and the USA (37). During this period 1128 students passed the state final examinations for comprehensive nurses. But there were also 705 nurses registering from hospital based programmes. It is not possible to determine from the information in the report of the Nursing Council any relationship between the comprehensive registration and the country of

destination, and the year that they became registered. All that can be shown is that 48% of nurses who sought verification of their New Zealand registration were registered comprehensive nurses.

Between 1 April 1989 and 31 March 1990 there were 1154 verifications for registration, of whom 679 (59%) had comprehensive registration, and 565 had registered since 1988. Again there were some 559 nurses from hospital based nursing programmes, and it is not possible to determine the actual numbers of comprehensive nurses from the figure of 565. There is, however, a clear change in overseas destination able to be identified here, with a decrease in the number for the United Kingdom (477) and increases in the numbers for Australia (410), Canada (126) and the USA (121). A total of 1337 applicants undertook the state final examinations during this year of whom 1239 passed. By 1991, verifications were provided for 976 nurses, of whom 648 were registered comprehensive nurses and 449 had registered since 1989. However, the number of nurses from hospital based nursing programmes had now decreased to 346. Of the 976 verifications, 468 were for the United Kingdom, 254 for Australia, 141 for the USA and 98 for Canada.

The 1992 figures show that 841 verifications were sought from which 591 had comprehensive registration; 368 of whom had registered since 1990. The pattern for destination is altered, showing United Kingdom (347), United States of America (231), Australia (168) and Canada (62). In 1993 the figures show a decrease in the number of verifications (598), but of this number, 412 had comprehensive registration and 205 had registered since 1991. A decrease in the number of verifications for the United States of America is apparent (76). with an increase to 4 for Singapore from previous years in which there had been 1-2.

These figures provide some substance to the statement that large numbers of new graduates from comprehensive nursing courses were indeed seeking employment overseas. However, nurses have always done this. It could be said that nursing education was being used as a scapegoat for concerns about the unstable health environment, and the place of nurses in that environment.

Perceptions of nursing education

As previously noted, one of the requirements of the NZQA for approval of undergraduate degrees is consultation with the wider community. Determining who 'the wider community' is, or indeed 'society' with whom the nursing profession is said to have a 'social contract' is in itself problematic. Nonetheless there are groups who purport to have a 'consumer' view, and with whom consultation occurs - albeit, it must be considered, in a somewhat tokenistic way. The perspective of one consumer group - the National Council of Women - which had previous formal involvement in nursing education (refer to the "1.6 committee", chapter five) is worth noting here. This perspective reflects perceptions about the change in the delivery of nursing education courses from hospitals to polytechnics as well as beliefs held about the educational process. This view asserts

The consumer is entitled to be:

- confident that the practitioner has undertaken the requisite training and can function to a standard determined by experts in that field
- assured that the practice will be kept up-to date by the implementation of new technology and knowledge as it becomes available
- assured that there is provision for the maintenance of standards of professional practice (Eisig, 1991:25).

There can be no argument with these comments. In fact they sit comfortably with the view that ongoing education is part of a nurse's accountability. But they are linked to a suggestion that students do not undertake adequate clinical experience:

The National Council of Women has frequently expressed concern that the present training system for comprehensive nurses does not necessarily result in nurses who are fully competent on registration to undertake the work required of them as autonomous practitioners. The institute-based courses do not seem to provide adequate practice in the nursing skills which are fundamental to nursing care. Nursing is a hands-on occupation and competence in the actual physical care of patients is basic. In particular, our members question whether training is suited to the hospital situation today - ie where only the grievously ill or injured are treated, catering for patients whose needs are urgent, and in the first instance are wholly physical. We believe there is a need for a period of 'apprenticeship' before final registration. Almost all professionals expect a period of practical work before registration is completed, and we certainly do not think that nurses, who's (sic) competence is so vital should be different (Eisig, 1991:25).

Several aspects of this statement should be noted. First, to whom concern has been frequently expressed is unknown, and second, there does not seem to be any basis for the suggestion that there is a deficiency in the development of nursing skills. And third, the matter of internship is raised in suggesting that new graduates are not competent in clinical areas on completion of their nursing education courses.

The insistence of the need for some sort of internship seems to be ongoing in relation to the graduates of comprehensive nursing education, and at a conference in 1995 was debated at length by nurses in New Zealand, with an agreed outcome that internship was not necessary (refer to appendix five). In addition, the perception that nursing is only concerned with practical activity is one which is made frequently in New Zealand. The knowledge that underpins nursing education is given no attention. This repeated assertion about nursing's practical base is seen to relate to the ability of graduates to function in clinical areas the moment they enter

them as registered nurses. It seems that there is little, if any, understanding by individuals and groups outside nursing about the requirements of comprehensive nursing courses for half the course to comprise clinical experience. This appears to indicate that how nurses are prepared for registration within a system of nursing education is not understood. Two important, but interrelated issues, can be identified at this point. First is whether there is actually any agreement among and between nurses that the direction of nursing education in the introduction of degrees is accepted, and second, if there is agreement, then how is this promoted. As chapter nine will identify, the introduction of cultural safety challenged the content of nursing courses and illustrated significant misunderstanding about nursing education, particularly in relation to different knowledge paradigms. Since all nursing education courses to obtain registration as a nurse in New Zealand offer this preparation within a degree framework, that this is appropriate to the stated intentions of nursing education seems something which needs to be continually communicated.

Although the medical profession was silent in relation to the establishment of undergraduate degrees in nursing education, it is of interest to note that in 1984 two statements were made within a submission to the Nursing Education and Review Committee in relation to the appropriateness of technical institute nursing courses to the needs of the health services. The first stated that

The medical profession has on the whole been critical of the advisability of this transfer of nursing training and in general has opposed the moves to transfer the majority of nursing training to the technical institutes (NZMA, 1981:1, cited Department of Health, 1988:38).

It was accepted by the New Zealand Medical Association that it was unlikely that the transfer of nursing education into the tertiary education system would be be

reversed, but it is to be noted that this group also held the view that it was necessary for graduates of comprehensive nursing courses to have a year of internship (Department of Health, 1988). Thus it can be argued that the implication of this comment is that the medical profession believes in (and perpetuates) the notion that there are inadequacies in comprehensive nursing preparation. The second statement of note by the New Zealand Medical Association relates to its views about university education for nurses. It was declared that it

believes that the emphasis in post-graduate nursing training should be on clinical training as with the medical profession. The association would not support any further extension of the University Nursing Course (NZMA, 1984:5, cited Department of Health, 1988:38).

Although there is no rationale given for this belief, it could be deduced from this that the medical profession does not consider nurses should have access to higher learning. It perpetuates the hegemonic and dominant view that nurses do not need to know how to think, only to 'do'. This reinforces the belief that the technical knowledge is the focus of nursing education.

Despite dissension and debate about degree programmes in nursing, all nursing courses in polytechnics in 1997, offer such degrees. But there are tensions in relation to the statutory responsibility of the Nursing Council of New Zealand and that of the New Zealand Qualifications Authority, which need to be examined.

Nursing qualifications and the registered nurse

The Nursing Council of New Zealand, while approving nursing education curricula, does not approve degrees, which is the domain of the New Zealand Qualifications Authority. It is helpful to discuss briefly the reasons behind the establishment of this latter body, so that its purpose within nursing education is clear. The establishment of the New Zealand Qualifications Authority was through the enactment of the Education Amendment Act 1990. The purpose of the Education

Amendment Act 1990 was

to reform the further administration of education and in particular to reform tertiary education and training with a view to -

- (a) Giving tertiary institutions as much independence and freedom to make academic, operational, and management decisions as is consistent with the nature of the services they provide, the efficient use of national resources, the national interest and the demands of accountability; and
- (b) Establishing a consistent approach to the recognition of qualifications in academic and vocational areas; and
- (c) Encouraging a greater participation in tertiary education and training, in particular by removing barriers to access for those groups of persons who have previously been under-represented; and
- (d) contributing to a dynamic and satisfying society by promoting excellence in tertiary education, training, and research (Education Amendment Act, 1990, Section 1).

The purpose of the New Zealand Qualifications Authority, after its establishment in 1991, was stated in its corporate plan as being concerned to

promote improvement in the quality of education and training in New Zealand through the development and maintenance of a comprehensive, accessible and flexible National Qualifications Framework (New Zealand Qualifications Authority, 1992-93:2).

In order to establish this national qualifications framework, which comprised eight levels of qualifications, consisting of a number of units (NZQA, 1991), there was a need to form advisory groups to develop unit standards by which to locate national qualifications on this framework. Nursing was cautious about the establishment of an advisory group, as well as concerned about the location of nursing qualifications on an education and training framework. In particular this caution was related to the development of units that would fragment aspects of nursing seen to be common to other disciplines in the health area (Williams, 1992-93). Of particular concern is the difficulty with standards by which to measure

nursing practice which seem to ignore that nursing practice is grounded in knowledge. A particular tension can be seen to exist in relation to the notion of such a framework of competence, which seems to be entrenched in the technical-rational model of efficiency and skills (Schon, 1987), and the emphasis on education which produces a registered nurse with knowledge and skills relevant to the health needs of society. Despite considerable discussion and debate, whether or not nursing qualifications should be located on this framework has not been resolved.

Contemporary international influences in relation to curricula are usefully examined at this point, since they were occurring around the time that undergraduate nursing degree programmes were being established in New Zealand, and it is to these that the discussion now turns.

Revolutionising the curriculum

Degree level nursing education programmes heralded significant potential for change both in the approach to teaching processes and the organisation and content of curricula. At around the same time that nursing education in New Zealand was moving towards the establishment of undergraduate degrees in nursing, on the international nursing scene there had been a shift in thinking about curricula in nursing education. In the United States of America in 1987, a national conference for nurse educators influenced the direction of nursing education curricula. What was identified was that it was no longer appropriate for nursing education to utilise a behaviourist model by which to prepare nurses of the future (Diekelmann, 1988; Bevis, 1988; Tanner, 1990). One of the greatest proponents for the use of a Tylerian model for nursing education curricula, Em Bevis, who, as noted in chapter six of this thesis, authored an authoritative and widely used text, became one of its greatest opponents. Essentially the emphasis on the need for change was on the failure of nursing education to effectively and adequately prepare nurses. These

allegations did not relate to the ability of nurses to function as registered nurses once entering the workforce as new graduates, but rather on their overall preparation to meet the needs of the health service. This is clearly stated by Watson (1988:423), who points out that nursing education has

failed to address the issue of how to educate and continue(s) to prepare a first level “product” for institutions; and ... failed to address the issue of how to prepare educated nurses as full health-care giving professionals

The arguments against behaviourism have been briefly raised in chapter six. The themes of the discussion that emerged from the 1987 conference - *Curriculum Revolution: A Mandate for Change* provided for nursing at least, compelling reasons why the continued use of behaviourist curriculum models was considered inappropriate for nursing education. Essentially the arguments for change can be seen to be associated with beliefs about knowledge and the processes of teaching and learning (Diekelmann, 1988). It is suggested that what is needed in nurse cannot be learned through the behaviourist model, since it does not permit “an education that will teach persons to think as well as act; to know, to continually seek a better knowing...” (Bevis and Watson, 1989:81). The emphasis in the nursing literature urges nurse educators to move from this model to models which empower students to develop critical and reflexive thinking, which has the potential to transform nursing practice (Clare, 1991). At the essence of the notion of curriculum revolution is concern for transformation of the health system (Perry and Moss, 1989; Bevis and Murray, 1990; Tanner, 1990).

Essentially the notion of a transformative curriculum is seen to be actualised through the teaching-learning relationship, in terms of empowerment and emancipation of students, as well as a redefinition of the student-teacher relationship (Allen, 1990). The views of Freire (1970) have been utilised in

illustrating reasons why there needed to be changes in thinking about the curricula. Freire's beliefs are predicated on notions of oppression, which he asserts stems from the "banking" concept of education, in which

knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing. Projecting an absolute ignorance onto others, a characteristic of the ideology of oppression, negates education and knowledge as processes of inquiry (Freire, 1970:58-59).

Freire (1970) asserts that this serves to regard students as objects to be managed; as repositories in which knowledge is to be stored, and as a result, there is an inability on the part of learners to think critically. What they do is receive the knowledge of the 'expert'.⁷ Emancipatory teaching practices thus have an empowering potential for students to become critical thinkers as well as creators of their own knowledge, through reflexive activity.

Degrees of purpose

The potential for the construction of a different nursing identity from that previously prepared through the hospital based system of apprenticeship training or within the structure of a diploma can be seen to be reflected within contemporary nursing education curricula. This is apparent both in the aims and outcomes of these curricula as well as in the strategies for teaching and learning. For the purposes of illustrating this, the outcomes of the one nursing course that commenced one of the first undergraduate degrees in nursing in New Zealand in 1992 are summarised.⁸ This polytechnic nursing course states that following satisfactory completion of the programme the new graduate will be able to:

⁷ There is a similarity between Freire's (1970) notion of banking education and the notion of received knowledge advanced by Belenky et al (1986).

⁸ This information has been obtained from the curriculum document from this polytechnic's nursing course. This is a public document.

- Comprehend, explain and apply foundation knowledge and skills and demonstrate attitudes which are the basis for nursing practice;
- Implement safe, effective, ethical and sensitive client care;
- Demonstrate effective and competent problem solving skills as an individual practitioner or as a member of a multiprofessional health team;
- Apply basic management skills, prioritise goals, show and understanding of resource limitations, and analyse costs in relation to benefits;
- Competently and actively contribute to health promotion and education activities for individual clients and in the wider community;
- Critically analyse client care regimens, be receptive to new knowledge and maintain the ability to learn throughout their professional career;
- Demonstrate culturally safe behaviour and an understanding of cultural, ethnic and socioeconomic differences and influences on client and self;
- Demonstrate leadership in nursing and health care issues;
- Meet Nursing Council of New Zealand requirements for registration as a comprehensive nurse (Otago Polytechnic, 1991:8-9).

The outcomes of this programme summarised above need also to be considered in the light of the requirements of the Nursing Council of New Zealand. While there may be a view that to become a registered nurse prepared adequately to meet the health needs of society for the future, the Nursing Council does not seem to be able to reflect this in its standards for the registration of comprehensive nurses. These standards remained essentially unchanged when degree programmes commenced in 1992. This makes it possible in New Zealand for the perpetuation of nursing courses that are not at undergraduate degree level, simply by having curricula approved by the Nursing Council which can demonstrate that the standards for registration are being met. In addition, the ultimate test for entry to the register of nurses remains the state examination, provision for which has been in existence in

New Zealand since the enactment of the Nurses Registration Act 1901. In essence, this means that there is still an emphasis on demonstrating that particular knowledge is evident in each applicant for registration, since the examination for entry into practice as a registered nurse is prescribed by the Nurses Regulations 1986. Each applicant must achieve

A pass in the State Examination for comprehensive nurses comprising the theory and practice of medical, surgical, psychopaedic, psychiatric, and community health nursing with reference to the scientific basis for nursing, including the administration of safe and competent nursing care, and the legal and ethical responsibilities of the comprehensive nurse (Regulation 3 (b)).

Paradoxically, perhaps, the standards for registration are not ordered around these medically based concepts, but since these are enshrined in legislation, they are undoubtedly a focus for nursing education courses. That this happens has been identified in the research of Judith Clare (1991) who found that since the state examination is the gatekeeper for entry into practice, nurse teachers work hard to ensure that students are prepared for this examination.

The normalising effect of this examination means that the nursing identity continues to be shaped through technologies of power, in particular, technologies of domination, in the sense that there are requirements for knowledge to be structured in a certain way. Thus despite the expressed need for nurses to be prepared in a way that recognises emancipatory and empowering processes, the examination reinforces the need for passively learning quantities of material according to the received view of knowledge (Belenky et al 1986). In recognition of this, perhaps, the Nursing Council has developed an alternative system for determining whether entry to the register can be achieved, in the form of a set of competencies (refer to appendix six). These have been developed in co-operation with nurses in education and practice throughout New Zealand, and have been introduced into polytechnic

nursing courses (Nursing Council of New Zealand, 1997). However, the effect of these is that an additional mechanism of surveillance has been added to the evaluation activities within each nursing course. These competencies are associated with the determination of the Nursing Council to exercise its statutory authority in ensuring that nursing courses meet the requirements for standards of registration. This authority has, in part, been exercised following the introduction of the concept of cultural safety, when it was identified that monitoring of nursing education curricula was not taking place. This challenged nursing in an unprecedented way, and this will be explored in the next chapter.

In summary, this chapter has explored and analysed issues of power and knowledge in relation to the establishment of degrees on nursing. It has illustrated that factions of society, including the nursing profession to some extent, has an ambivalence about an educated nurse. Despite the potential for nursing curricula to shape a different nursing identity, there remain requirements for knowledge to be structured in a particular way, as well as a belief that nursing education should focus on technical knowledge.

SECTION THREE

NOTIONS OF A DIFFERENT IDENTITY

This final section of the thesis consists of four chapters. Chapter nine describes and analyses the notion of cultural safety, both in terms of its introduction into nursing education, as well as its place in relation to the nurse and nursing knowledge. It argues that a curriculum requirement for nursing education illustrates how nursing has introduced emancipatory knowledge into the knowledge base for nursing.

Chapter ten focuses on the power/knowledge interrelationship apparent in the regulation and statutory control of the nurse, and illustrates Foucault's notion of governmentality in relation to technologies of domination and technologies of the self, which create the nursing identity through a legislative governance.

Chapter eleven continues with the notion of governmentality, but relates it to discourses that have emerged in nursing and nursing education as nursing seeks to shape a nurse with specifically defined attributes, different from those of the nurse at the beginning of this century. These discourses highlight the power/knowledge interrelationship in the creation of the nurse, as through technologies of the self, the nurse implicates herself in her own creation.

Chapter twelve is the final chapter of this thesis. It draws together the argument of this thesis and explores the (re)positioning of the nurse in terms of possibilities for resistance.

CHAPTER NINE

CULTURAL SAFETY AND NURSING EDUCATION

On 25 July 1995, Ian Revell, a member of the New Zealand Parliament who also chaired the Education and Science Select Committee of Parliament, released a press statement which outlined an intention for that committee to undertake an enquiry into the cultural safety component of nursing education curricula. The press release stated his reasons for this enquiry were because he believed that there was

justification to hold such an enquiry to address this complex and contentious issue from the enormous number of public expressions of concern I have received and the correspondence generated on this matter. Clearly, there is more than enough support in the community for such an investigation to take place with many people believing that it is long overdue (Revell, 1995:1)

The introduction of cultural safety into nursing education and the subsequent controversy which surrounded it exemplifies many of the issues discussed in this thesis. In particular it is used in this chapter to emphasise the interrelationship between knowledge and power in nursing education which is the central focus of this thesis. While negative public reaction to its introduction into nursing education may point to views that society holds about nurses and nursing education, and accordingly, the knowledge that is necessary to be a nurse, what can also be illustrated through an analysis of what cultural safety is, and how it came to be part of nursing education, is the way in which attempts are made to subjugate and silence certain knowledge. What appears to have been overlooked and misunderstood in criticism of the concept of cultural safety and its introduction into nursing education, are the reasons for it as a requirement of the knowledge base for nurses and midwives being prepared for registration, as well as the implications it has for nursing and midwifery education and practice. Viewed from a critical theoretical perspective, however, the emancipatory intentions of cultural safety

seem clear. This chapter therefore explores how the concept of cultural safety became a requirement for inclusion in all nursing and midwifery education courses in New Zealand in 1991, as well as how what is essentially the nursing education curriculum came to be the subject of investigation by the New Zealand Parliament.

Cultural safety and nursing education

In 1991, the Nursing Council of New Zealand resolved to introduce the concept of cultural safety into nursing education courses, and to include it as part of the State Final Examination for nurses. At the time it was introduced it was defined as

The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurses' culture on own nursing practice (Nursing Council of New Zealand, 1992a:1).

Part of the rationale for the introduction of cultural safety into nursing education courses is stated to be that it is to address recognition of difference between and among individuals. As Ramsden (1995) explains, generations of nurses, on completion of a nursing education programme in New Zealand, swore the Florence Nightingale oath at graduation ceremonies, within which was a statement that people should be nursed *regardless* of colour or creed. Traditionally nurses were educated not to recognise people's differences in the provision of nursing care, but to treat them all the same. It is believed that health professionals operating from assumptions and stereotypical attitudes can compromise how safe people feel about using a health service which places their health at risk. Cultural safety requires that nurses care for people *regardful* of those things which make them unique.

The inclusion of cultural safety within nursing education courses, aims to challenge students to identify that there are different ways by which people experience life and view the world. The initial guidelines developed by the Nursing

Council of New Zealand for the teaching of cultural safety to nursing and midwifery students seems to make this clear. Within these guidelines is a statement which particularly identifies the ethnocentricity inherent within an individual's values and beliefs:

Being a member of a culture surrounds each person with a set of activities, values and experiences which are considered to be real and normal. People evaluate and define members of other cultural groups according to their own norms. When one group far outnumbers another or has the power to impose its own norms and values upon another, a state of serious imbalance occurs which threatens the identity, security and the ease of other cultural groups, thus creating a state of disease (Nursing Council of New Zealand, 1992a:1).

The aspect of the nursing curriculum within which the notion of cultural safety is positioned is designed for students to identify their social and personal attitudes, and have an opportunity to examine their beliefs, values, and assumptions about other people. Its emphasis is on recognition of the inappropriateness of imposing one set of values and beliefs that a nurse may have on another person or group of people. The focus of cultural safety is not, therefore, on developing ethno-specific knowledge of other groups, but rather its focus is to educate student nurses and student midwives

- * to examine their own realities and the attitudes they bring to each new person they encounter in their practice;
- * to be open minded and flexible in their attitudes toward people who are different from themselves, to whom they offer or deliver service;
- * not to blame the victims of historical and social processes for their current plight;
- * to produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practice (Nursing Council of New Zealand, 1992a:1).

It seems clear from its stated focus that the essence of cultural safety is personal identification of attitudes that an individual may have towards a person or a group of people who may be different from the nurse. It is suggested that as nurses can be the first health professional people meet in the health system, the attitude a nurse portrays is crucial. As Ramsden (1995) asserts, if a nurse has an attitude of criticism, blame or assumption - whether expressed knowingly or unknowingly - this may make a person feel demeaned and engender feelings of reluctance either to seek health care or to return to a particular health service. Thus in terms of attitudes, the expectation from the inclusion of cultural safety in nursing education is about nurses and midwives being non-judgmental towards others. To do this, awareness of self attitudes is a critical component. This self-awareness is linked to the notion of emancipatory knowledge, which Habermas (1987) makes clear, functions to critique how social domination and repression are reinforced through social structures.

Two questions arise from the assertions about the necessity for students to examine their attitudes within the broader notion of cultural safety in a nursing education course. First, whether it is possible to determine if what may be referred to as negative attitudes exist, and second if it is known what effect such attitudes might have on others. Immediately this becomes problematic. While there is anecdotal evidence of the harmful effects of being stereotyped or having assumptions made about being different from the dominant culture of a health professional, this is not considered adequate by those who would wish to see evidence in terms of cause and effect. In addition, attitudes may be too entrenched for individuals to recognise their existence until they are exposed to the way in which they have developed an attitude towards a particular thing, person or group of people. In addition, as will be discussed later in this chapter, cultural safety initially sought to address matters of racism within New Zealand society in the sense that it aimed to emphasise

awareness of attitudes towards Maori people of New Zealand in relation to health care provision.

Definitions

It is helpful to look now at the way in which the concept of cultural safety has been constructed, since it illustrates the potential for confusion about the concept in the context of knowledge in nursing education. Within the Nursing Council's definition, the term 'culture' is used in a broad sense, and incorporates many elements, such as a particular way of living in the world, attitudes, behaviours, links and relationships with others (Nursing Council of New Zealand, 1992a).

The term culture has a variety of meanings. For example Collins (1988) thesaurus provides the synonyms of "civilization, customs, lifestyle, mores, society, stage of development, the arts, way of life, accomplishment, breeding education, elevation, enlightenment, erudition, gentility, good taste, improvement, polish, politeness". It is fair to say, however, that the term culture is used in everyday language in New Zealand anyway, to depict the customs of particular ethnic groups. In other words, this has become the dominant definition. Within nursing, however, the term culture is not used in such a narrow sense. Aside from the Nursing Council of New Zealand's use of the notion of culture, the New Zealand nursing literature does not confine cultural values only to the concept of ethnicity. Cultural values are defined by the New Zealand Nurses Organisation, (1995:9) as "Morals, beliefs, attitudes and standards that derive from a particular cultural group. Culture is not seen as ethno specific, but must include groups from within cultures e.g cultures of class, socialisation, sexual orientation, age etc". What seems to have happened is that nursing has used the term 'culture' within its language to refer to it in a way that is either not considered to be appropriate or it represents only one meaning to most people.

But the same cannot be said for the notion of 'safety', which seems to have an agreed meaning. Safety is commonly used notion in relation to the practice of health professionals, and is used in other areas, such as legal or ethical safety to refer to whether someone is safe and/or competent in practice. The Nursing Council of New Zealand has clearly stated expectations of safety in nursing and midwifery practice, where it is defined as

... nursing or midwifery action to protect from danger and/or reduce risk to patient/client/community from hazards to health and well being. It includes regard for the physical, mental, social, spiritual and cultural components of the patient/client and the environment. Unsafe nursing or midwifery practice on the other hand is defined as ... any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/client (Nursing Council of New Zealand, 1995:2).

As already identified, the Nursing Council of New Zealand is the statutory authority which governs nurses and midwives in New Zealand. It is empowered by the Nurses Act 1977 to do this through setting and monitoring standards to ensure safe and competent care for the public of New Zealand. The argument for the introduction of cultural safety is that it was considered to be *one* aspect of safe nursing and midwifery practice relevant to the provision of care for all people of New Zealand. Its place in nursing and midwifery education course requirements, therefore, relates to being one of several outcomes required of each applicant for registration as a nurse or midwife (Nursing Council of New Zealand, 1992a).

This essentially means that cultural safety is part of an educational process rather than an anthropological concept. It can be seen that cultural safety does not place an emphasis on sensitivity or an awareness of other 'cultures'. Cultural sensitivity and cultural awareness are both concerned with having knowledge about cultural, but more specifically, ethnic diversity. It is this that seems to be the basis of

misinterpretation of the concept of cultural safety. The term 'culture' is taken to mean 'ethnicity', and in New Zealand culture is seen to be Maori. And since students explore their attitudes in terms of exposure to the effects of colonisation in New Zealand and issues of power, it is not difficult to see why there is misunderstanding and confusion about what cultural safety means.

In terms of the notion of cultural safety, it is asserted that the skill for nurses and midwives does not lie in knowing the customs of ethnospecific cultures. Its emphasis is to place an obligation on the nurse or midwife to provide care within the framework of recognising and respecting the difference of any individual. Rather than the nurse or midwife determining what is culturally safe, it is consumers or patients who decide whether they feel safe with the care that has been given (Ramsden, 1995). Cultural safety within nursing and midwifery addresses power relationships between the provider of a service and the people who use the service in that the users of the service are empowered to express degrees of felt risk or safety. The basis for this is the assertion that someone who feels unsafe because their culture (in its broadest sense) is different from that of health professionals whom they encounter in the health service may not be able to take full advantage of the primary health care service offered and subsequently avoid the service until dramatic and expensive secondary or tertiary intervention is required (Ramsden, 1995). The idea of cultural safety therefore

Assumes that each health care relationship between a professional and a consumer is unique, power-laden, and culturally dyadic. From this perspective, whenever two people meet in health care interactions, it inevitably involves the convergence of two cultures. This bicultural component not only involves unequal power and different statuses but it also often involves two cultures with differing colonial histories, ethnicities or levels of material advantage (Kearns and Dyck, 1996:X).

This quotation makes it clear that cultural safety in nursing and midwifery

education and practice provides a focus for thinking about power relationships and people's rights. In this sense, it is more about the nurse than it is about the patient or person seeking assistance for a health need. But this is not the way that it was seen by some members of society. Instead it has been portrayed as a tyrannical concept which instills fear into the hearts and minds of nursing students. This is most likely because of its close association with the Treaty of Waitangi, and it is important to examine this relationship at this point.

The Treaty of Waitangi and cultural safety

During the middle of the nineteenth century New Zealand was colonised by Great Britain. In 1840 a treaty was signed between the British Crown and the Maori people who inhabited New Zealand at that time. This Treaty - the Treaty of Waitangi - provided guarantees that the indigenous people (the *tangata whenua*) would have certain rights. It needs to be noted that there are different versions of the Treaty of Waitangi,¹ which in part accounts for debate about breaches of rights or otherwise by successive generations of New Zealanders in government. However, despite promises of equality embodied in the Treaty of Waitangi, it became apparent that the *tangata whenua* - Maori people - have not received the same benefits as other (non-Maori) people of New Zealand from the health service. A report on Maori standards of health published in New Zealand in 1988 identified that Maori were culturally, socially and economically disadvantaged. This was reflected in high unemployment levels, poor educational achievement, and significantly high rates of physical and mental illness (Pomare and de Boer, 1988). Soon after the release of the report, it was acknowledged by the Director-General of Health that these statistics reflected the deterioration in Maori health after 150 years of European influence in New Zealand (Chapman, 1988). This explicitly

¹ For further elaboration concerning these different versions, refer to Orange (1989), *The story of the Treaty*.

identified imbalance between non-Maori and Maori health status was seen as irrefutable evidence of a relationship between poverty and health. Clearly there was an urgent need to redress this, and education was an obvious place to begin.

The introduction of cultural safety into nursing and midwifery education, it has been argued, developed from a concern to develop ways of dealing with

social, economic, political, historical and often emotional reasons for the high incidence of rheumatic heart disease, the rates of asthma deaths, cot deaths, mental hospital readmission rates, uptake of tobacco smoking among young women, the rapid rise in high risk behaviours and suicide, in which one section of the New Zealand population far exceeds the rest. The people in this sector are Maori” (Ramsden, 1995:3).

In line with government policies on improving Maori health, there is a legislative requirement for statutory bodies and government departments to conduct their activities in a manner consistent with the Treaty of Waitangi as a result of the enactment of the The Treaty of Waitangi Act 1975 and its amendment in 1985. The Nursing Council of New Zealand is in effect an agent of the Crown through its statutory role in the maintenance of standards of education and practice for nurses and midwives. Its affirmation of the Treaty of Waitangi was first acknowledged in a three year strategic plan published in 1994, in which it was stated in one of its critical strategic issues that the Nursing Council would address its role in relation to the Treaty of Waitangi (Nursing Council of New Zealand, 1994). Within the health service all Ministry of Health policy documents specify the priority of Maori health. Additionally, involvement of Maori and the funding of Maori health initiatives are required of the four Regional Health Authorities, which fund the provision of health services in New Zealand. The New Zealand Government has affirmed the Treaty of Waitangi as the founding document of New Zealand, and stated through the Department of Health (1992) a goal of improvement in Maori health status.

These requirements, however, seem to have been overlooked by critics unable to understand reasons for the inclusion of cultural safety within nursing education course requirements. It could be said that cultural safety in nursing education is doing two separate but interrelated things. First, to address attitudes that may either consciously or unconsciously exist towards cultural differences in the provision of or access to health services and secondly as a way of addressing imbalances in the status of Maori health through acknowledgement of the Treaty of Waitangi.

It is this dual feature of cultural safety that seems to have created opposition to, and confusion about, its intentions. What seems to be misunderstood is that through teaching about the effect of colonisation on the health of a particular group - in this instance Maori health - it is seen to be only addressing one 'culture'. This matter is further exacerbated by those members of society who either do not understand the guarantees provided by the Treaty of Waitangi in terms of Maori, or do not want to. It can also be argued that the issue of the status of Maori health is not seen to be an issue with which nurses should be concerned. This is apparent in relation to some of the adverse comments about its introduction, which will be discussed later in this chapter.

How cultural safety came to be part of nursing education

The background to the introduction of cultural safety into nursing education needs to be discussed at this point. The significance of this is to show how the micro politics of power operate, and in order to do this the historical axis of the framework for analysis in this thesis is utilised. In addition, it illustrates how nursing recognised the need to address inequalities apparent in Maori health status through emancipatory knowledge in nursing education curricula.

Prior to the publication of the report on the status of Maori health published in 1988, (Pomare and De Boer, 1988), nurses in New Zealand were already aware of problems of Maori health and how the education of nurses could be a positive force in relation to this.. A national workshop in 1986 which reviewed the preparation and initial employment of nurses recommended that more Maori nurses in the nursing workforce was essential (Department of Health, 1986). In 1987 a Maori nurse advisor and educationalist - Irihapeti Ramsden - was seconded to the Department of Education to assist in the development of guidelines for curriculum in nursing education within polytechnic schools of nursing. Various formal and informal hui (meetings), widely supported by nurse educators, were held throughout New Zealand to discuss these curriculum matters (Ramsden, 1995). Formalisation of the concept of cultural safety began in 1988 at a hui in Christchurch, which was attended by Maori student nurses and nurse educators. A further hui was held during 1989 for Maori nurse teachers, and from this a group of Maori nurses were nominated to prepare a set of cultural safety standards.² The standards that were developed were given the Maori term *Kawa Whakaruruhau* - which translates into cultural safety (Nursing Council of New Zealand, 1992a).

One of the members of this group, Irihapeti Ramsden, was a member of the Education Committee of the Nursing Council of New Zealand. This committee had responsibility for the development of standards for education which were submitted to the Council for approval. The Nursing Council of New Zealand resolved to make cultural safety a requirement in the state examinations for nurses and midwives in 1991, and in the same year it commissioned the writing of guidelines to assist schools of nursing in the implementation of cultural safety into the education of nurses and midwives. These guidelines under the term *Kawa*

² A detailed explanation of this process can be found in the many articles authored by Irihapeti Ramsden between 1991 and 1995.

Whakaruruhau were formally adopted by the Nursing Council in February 1992. At the same time the standards for cultural safety were formally adopted by the Nursing Council of New Zealand, it was resolved that the state examinations for nurses and midwives would include a component of cultural safety (Nursing Council of New Zealand, 1992b).

The inclusion of this requirement, which represented around 20 percent of the state examination, now meant that candidates for registration had to demonstrate that in addition to being academically and clinically competent, legally and ethically safe, they had to be culturally safe (Ramsden and Spoonley, 1993). In terms of the definition of cultural safety promulgated by the Nursing Council of New Zealand, what this meant in such an examination was that the candidates' answers in respect of any questions relating to anyone else different from them, would reflect that the actions of the candidate would not place any patient or client at risk. It seems clear that this is no different from the theoretical, clinical, legal and ethical components of these examinations. The guidelines were subsequently distributed to schools of nursing for inclusion in curricula. It was not as if this was something that was totally unexpected by any of the fifteen comprehensive nursing courses in New Zealand. Intentions for this requirement for cultural safety to be included and its place in the state final examination had earlier been communicated in circular letters to schools of nursing (Nursing Council of New Zealand, 1991/5, 1991/6).

Once the guidelines for the teaching of cultural safety were distributed they were in effect a public document. Soon after their distribution to schools of nursing an article appeared in *Metro*, which illustrates how the meaning and rationale for cultural safety was distorted by the media:

From November, student nurses may fail their State Final registration exams if they don't follow the party line on the Treaty of Waitangi objectives. From this year 20 per cent of the State Final exam will be on something called "cultural safety", a concept involving sensitivity to Maori (but not Pacific Island, Indian, Chinese or any other minority) cultural differences, anti-racism, and a liberal interpretation of the Treaty of Waitangi (Du Chateau, 1992:86).

This was to be the first - but not the last - time the media was to take up the positions of the dominant discourse in New Zealand of 'multiculturalism'. To view the content of these guidelines out of the context of any total curriculum, however, and comment on them publically as Du Chateau (1992) did, distorted the intent of the guidelines. The Nursing Council's (1992a) guidelines do contain material which could be seen as controversial and might make good copy from the perspective of a journalist (refer to Appendix 7). The inclusion of cultural safety in nursing education clearly had unintended consequences, and this was soon to become apparent.

Controversy and confusion

Cultural safety became associated with notions of 'political correctness' (Haden, 1993). This essentially arose from three separate situations, in which two nursing students and a tutor associated with different nursing courses drew attention to the notion of cultural safety in nursing courses. In all of these the media has to be seen as an accelerant to public debate. The first incident was in 1993 following the release to the media of a copy of a letter to various Ministers of the Crown and organisations and individuals by Anna Penn, who had previously been a student of the nursing course at Christchurch Polytechnic. She had not met course requirements for continuation in the nursing course, and asserted that this was because she had "failed a hui". The matter, it seems, was a personal grievance

between the student and the polytechnic, and a later public report released by the director of Christchurch Polytechnic made that apparent (Hercus, 1993). The publication of the viewpoint of a tutor in a nursing department in 1995 resulted in further media attention, and both cultural safety and the Nursing Council were portrayed in a negative light. Attention focussed on the tutor's complaints that standards were not being met within the nursing course because large amounts of time were being taken up with cultural safety at the expense of some areas of nursing, such as mental health nursing (Stabb, 1995).

With the attention given to both these situations, albeit over a two year period, the credibility of nursing education in general and graduates of nursing education courses in particular, was compromised. In the public debate that surrounded both of these incidents, there was little recognition given to the intended aims of cultural safety. Neither illumination or support was given to the concept by many nurses who instead referred to their own days of training where everyone was treated the same. Other nurses provided anecdotal examples of their negative experiences as students. In addition, the content and number of hours of 'nursing' in relation to the number of hours of cultural safety in nursing education courses was challenged. There were claims that cultural safety had replaced more traditional knowledge content, such as 'medical' knowledge, which, it was argued, produced deficiencies in graduates of comprehensive nursing courses and made it difficult for them to be accepted in overseas countries (Wills, 1993). This did little to dispel the developing belief that the preparation of nurses for registration was inadequate, and that the Nursing Council was failing in its public duty to ensure adequate standards of education for nurses.

It was the content of nursing courses that was identified by a nursing student from a nursing course at an Auckland polytechnic at a regional conference of a political

party as being of concern. She asserted that large numbers of hours were being spent on cultural safety and claimed that this compromised the important aspects of nursing education. She questioned whether it was more important for her to know about Maori issues or more important to know how to deliver a baby (Davies, 1995).³ In effect what was being challenged was any relationship between colonisation and disease from a Maori perspective of health. This clearly illustrates the belief that technical knowledge is privileged in relation to what is considered appropriate for nurses to know. It was hardly surprising that the result of this was further media attention to the notion of cultural safety. The press and cartoonists, combined with talkback radio and television, produced powerful negative and sometimes offensive images of nurses and nursing (Papps and Ramsden, 1996). More significantly, however, media representations of cultural safety highlights the role of the media as what Foucault (1980:132) describes as one of “a few great political and economic apparatuses” which function to produce and transmit ‘truth’.

Not long after this third incident of media attention, the Education and Science Select Committee of the New Zealand Parliament became involved with cultural safety. This committee hears public submissions and makes recommendations to Parliament. In this instance, nursing education, because of its location in the education system, was under scrutiny, ostensibly because of public expressions of concern received by the chairperson of the committee. That these concerns had been expressed to a member of Parliament in such volume is in itself a matter of interest, since the Nursing Council, with a statutory responsibility for nursing education curricula, was unaware of such a magnitude of public concern (Personal communication, Nursing Council of New Zealand, 1995). The Nursing Council of New Zealand was called to account to the Education and Science Select Committee in

³ There is no requirement in nursing education courses for nurses to learn to do this. The ‘delivering of babies’ comes within the scope of practice of midwives.

July 1995. However, by this time the Nursing Council by this time had established an independent committee to undertake an investigation into concerns that had been voiced, particularly in relation to the teaching of cultural safety in some polytechnic nursing courses. It had become apparent that there was some misinterpretation of the guidelines promulgated in 1992. The review of cultural safety was to be a four stage process, which was designed to:

- * review the relevant curricula from the fifteen Polytechnics which teach nursing education, and those documents already in the public arena;
- * call for public submissions;
- * conduct site visits to the relevant Polytechnics;
- * collate and analyse the information and report back to the Council (Murchie and Spoonley, 1995:6).

This committee thus reviewed the teaching of cultural safety by visiting all fifteen polytechnics, as well as interviewing students and staff, and reported its findings with a number of recommendations for the Nursing Council to address (Murchie and Spoonley, 1995). In the meantime, however, it was decided that the Education and Science Select Committee would conduct its own enquiry into cultural safety, and it called for public submissions. If there had been little opportunity for involvement by members of the public in the transfer of nursing education from hospitals into polytechnics, and what should or should not be part of nursing education curricula, there was certainly now an unprecedented opportunity for this to occur. Some of these submissions were 'received' during a talk-back radio programme on Radio Pacific on 5 August 1995, in which Ian Revell, the chairperson of the Education and Science Select Committee, and Margaret Austin, a member of Parliament as well as a member of that Select Committee, were the key participants. In this way, the voice of members of the public in relation to nursing

education course content was discussed through the media and accepted as 'evidence' that cultural safety was problematic. Again, the control of 'truth' by the media Foucault (1980) refers to demonstrates that truth claims are contingent on a struggle between different discourses. It is difficult to imagine the truth claims of the education of other occupations discussed through the media. Not all members of this committee, however, supported the decision for an enquiry through the parliamentary system. Tau Henare (1995) distanced himself from the rest of the committee, and in a press release to the media, referred to it as a 'witch hunt', stating that it was not for politicians to make decisions about the content of nursing education curricula.

When the Nursing Council reported back to the Education and Science Select Committee in October, 1995, this committee resolved that it would suspend its enquiry until such time as a report had been received from the Nursing Council concerning the eight recommendations made by Murchie and Spoonley as a result of their review of the teaching of cultural safety (Austin, 1995).

Recommendations to address issues in cultural safety teaching

There were eight recommendations promulgated from the review of the fifteen comprehensive nursing courses in New Zealand undertaken by Murchie and Spoonley (1995). These recommendations are important to note in that they identify issues that seemed to exist in the understanding and teaching of the concept of cultural safety, as well as issues in its teaching, and are provided here for the benefit of the reader.

1. That cultural safety be retained as an important component of nursing education and that it should continue to be identified as 'cultural safety'.

2. That the Nursing Council retains its current legislative responsibility for nursing education and registration, that the Council explores various initiatives to improve the delivery of cultural safety in nursing education and that it continues to explain the intention and practice of cultural safety.
3. That curriculum development for cultural safety is a priority at this point, and that the Nursing Council initiates a national review of curriculum requirements and establishes a group with a variety of specialist skills to update and improve the current curriculum and to distribute it as a set of guidelines to polytechnics.
4. That the Nursing Council, in conjunction with nursing educators and other relevant communities, should develop guidelines as to what constitutes good teaching practice and strategies in the area of cultural safety.
5. That the Nursing Council revisits the issue of qualifications required by those teaching cultural safety and that new guidelines be established.
6. That those who have responsibility for the management of cultural safety within the polytechnic nursing programmes, should consider what constitutes supportive and high quality management practice.
7. That the terms of reference and membership for Komiti Kawa Whakarurhau⁴ be carefully considered and discussed amongst the staff of departments of nursing.
6. That the Nursing Council, with the help of departments of nursing in the polytechnics, establish guidelines for the adequate assessment of students, and in turn, the student evaluation of tutors and cultural safety courses (Murchie and Spoonley, 1995:2-3).

It is apparent from these recommendations that one of the main issues in relation to cultural safety seems to be its actual name. As indicated earlier in this chapter, the definition of cultural safety refers to culture in its broadest sense. But the definition of the Nursing Council of New Zealand was not a generally acceptable definition by those who understood cultural safety in terms of ethnicity, and perceived it in relation to the 'multicultural' nature of New Zealand society. Thus it was linked to the discourse of multiculturalism, which now needs to be briefly examined to establish what this means in relation to the notion of cultural safety.

The discourse of multiculturalism

The confusion about cultural safety perpetuated by the media, that is that its purpose was to indoctrinate students about Maori customs and language, and a concept known as 'transcultural nursing' have all become merged into the debate about what cultural safety is. An approach to awareness of ethnic differences in nursing education and practice has emerged, through the work of an American nurse, Madeleine Leininger (1991). Leininger's notion of transcultural nursing is, however, a different concept from cultural safety. It is positioned within the discourse of multiculturalism. Transcultural nursing suggests that curricula need to contain ethno-specific knowledge about a variety of cultural groups to work effectively with patients or clients of other cultures. The risk in this is that all differences can become stereotyped. It can be argued that this is precisely what cultural safety seeks to avoid. Transcultural nursing in this respect can be seen as the antithesis of cultural safety teaching. Nurses and midwives have developed the concept of cultural safety in the New Zealand context, respecting the Treaty of Waitangi. In addition, it is consumers who judge whether they feel safe in terms of the care that has been accorded them. Critics of cultural safety suggest that since New Zealand is a multicultural society, transcultural nursing would be a more appropriate term than cultural safety (Revell, 1995; Smith, 1996). What is at issue here is that culture is regarded by such critics in its narrowest sense as meaning ethnicity and its meaning is associated with being sensitive to, and knowing about ethnospecific differences.

Instead of being seen as an emancipatory notion developed by nursing, cultural safety was considered to be inappropriate to nursing education, and was silenced and subjugated by attempting to marginalise it. The language spoken was that of the dominant discourse of multiculturalism. During the debate about the place of cultural safety in nursing education, this was assisted by the distortions accorded it.

There were unsubstantiated claims of grossly inflated hours of time devoted to its teaching, which, if they were accurate, would have indeed meant that nursing education was not adequately preparing student nurses for eventual registration as nurses. Despite the availability of information from the Nursing Council of New Zealand which provided an accurate picture of the actual hours of topics within nursing education curricula and refuted such claims, it seems that there was a determination for cultural safety to be removed from nursing education curricula, or at the very least, to be renamed (Nursing Council of New Zealand, 1996a).

That the term cultural safety has been retained in nursing education curricula in New Zealand suggests that nursing has successfully created a counter discourse through the naming of cultural safety in spite of the struggle for it to be called something else. It exemplifies what Foucault (1980) has identified, that where power is exercised, there is resistance. Hence in relation to the power/knowledge problematic, the strategic reversibility of power is evident. Additionally, since its introduction in 1992, cultural safety has continued to be refined. While its primary focus remains on improving the health status of all people of New Zealand through the relationship between Maori and the Crown based on the Treaty of Waitangi, it has been further developed to include an emphasis individuals and the relationship between nurses and midwives who differ from them by

- * age or generation
- * gender
- * sexual orientation
- * socioeconomic status
- * ethnic origin
- * religious or spiritual belief
- * disability (Nursing Council of New Zealand, 1996b).

Inclusion of these categories into guidelines for the teaching of cultural safety highlights that the concept of culture is used in its broadest sense and its emphasis on cultural aspects of difference where unconscious negative attitudes may exist in nurses providing care for others.

It seems paradoxical that there was a political reaction to cultural safety in nursing education yet statutory recognition given to the Treaty of Waitangi. The Minister of Health for New Zealand in 1996, the Hon. Jenny Shipley in endorsing draft guidelines for cultural safety in nursing and midwifery education commented that the nursing and midwifery professions in New Zealand are leading the world in addressing issues of transferring power from providers to consumers (Shipley, 1996). But it is a new concept which has yet to be fully evaluated. The Nursing Council of New Zealand has developed new guidelines for the teaching of cultural safety, which have been implemented and will be closely monitored. The real test of its efficacy in nursing and midwifery will be in practice where consumers will judge whether nurses and midwives are culturally safe. The measurability of the emancipatory intent of cultural safety, however, may make this difficult. The next part of this chapter explores cultural safety and its relationship with critical theory.

Cultural safety and critical theory

From the preceding discussion it can be seen that the emphasis of cultural safety is to emancipate thinking about attitudes that may be held in relation to difference. It can be argued that cultural safety is in effect a critical social theory, which as previously discussed (refer to chapter eight) has become important to nursing education because of its liberatory or emancipatory focus. Critical theory, according to Geuss (1981:2), is “a reflective theory which gives agents a kind of knowledge inherently productive of enlightenment and emancipation”. Thus

cultural safety in nursing education aims to develop an awareness of how the actions of an individual may be hidden or distorted through everyday understandings.

One way of describing how critical social theory does this is through utilisation of Brian Fay's (1987) work in the area of critical social science. He perceives critical social science as a systematic, unified and interrelated *complex of theories*, and explains that a fully developed critical theory would consist of four essential elements which has ten subtheories:

I *A theory of false consciousness* which

- 1 demonstrates the ways in which the self-understandings of a group of people are false ... or incoherent ... or both. This is sometimes called an "ideology-critique";
- 2 explains how the members of this group came to have these self-misunderstandings, and how they are maintained;
- 3 contrasts them with an alternative self-understanding, showing how this alternative is superior.

II *A theory of crisis* which

- 4 spells out what a social crisis is;
- 5 indicates how a particular society is in such a crisis. This would require examining the felt dissatisfactions of a group of people and showing both that they threaten social cohesion and that they can not be alleviated given the basic organization of the society and the self-understandings of its members;
- 6 provides an historical account of the development of this crisis partly in terms of the false consciousness of the members of the group and partly in terms of the structure of society.

III *A theory of education* which

- 7 offers an account of the conditions necessary and sufficient for the enlightenment envisioned by the theory;
- 8 shows that given the current situation these conditions are satisfied.

IV *A theory of transformative action* which

9 isolates those aspects of a society which must be altered if the social crisis is to be resolved and the dissatisfaction of its members lessened;

10 details a plan of action indicating the people who are to be the “carriers” of the anticipated social transformation and at least some general idea of how they might do this (Fay, 1987:31-32).

That the concept of cultural safety relates to these elements and subtheories seems clearly apparent viewed in relation to the stated aims of cultural safety espoused by the Nursing Council, as well as the requirements for inclusion in cultural safety education (refer to appendix seven). As Patricia Stevens (1989) identifies, critical theories are concerned with the interpretation of the history of the twentieth century in the sense that social phenomena cannot be understood in relation to its historical whole, as well as to the structural context in which it is situated. Cultural safety as a critical theory, has to be seen as a crucial aspect of nursing education in that if nurses are to be prepared for the future, they need to be able to recognise historical, political, social and economic structures as they affect health, as well as a willingness to take action in effecting changes to such structures in which these aspects occur. However, as Geuss (1981:51) reminds us, a critical theory

does not predict that the agents ... will adopt and use the theory to understand themselves and transform their society, rather it ‘demands’ that they adopt the critical theory, i.e. it asserts that these agents ‘ought’ to adopt and act on the critical theory.

The naming of the concept of cultural safety named the sociopolitical agenda of addressing the health status of Maori in relation to societal structures. This identifies cultural safety, in Foucauldian terms, as a discourse, which represents an alternative ‘truth’ that has arisen in recognising that there are certain knowledges which have been disqualified or subjugated. Not to have such knowledges included

within nursing education programmes privileges other knowledge, and dominant discourses are perpetuated. The interrelationship between power/knowledge is evident. As Foucault (1980:69) explains

Once knowledge can be analysed in terms of region, domain, implantation, displacement, transposition, one is able to capture the process by which knowledge functions as a form of power and disseminates the effects of power.

The location of cultural safety within a critical theory framework also suggests that requirements for its teaching need to be seen in terms of critical pedagogies (Giroux, 1983; McLaren, 1987). The tenets of critical pedagogies, Carmen Luke (1992:227) suggests, mean that

students are given the opportunity to articulate their cultural experiences, and if teachers help students to discover how they self-construct meanings and identities within and against the ideological framework of mass culture, institutional settings and discourses - then students will have the critical tools with which to act in morally responsible, socially just, and politically conscientious ways against individual and collective oppression. In this view, critical self-determination will lead to a democratic transformation ... of society.

In this respect, the intent of cultural safety as a requirement for nursing education curricula seems clearly emancipatory. But it has never been defined according to the tenets of critical social theory or critical pedagogy in any of the literature promulgated by the Nursing Council of New Zealand, despite its clear sociopolitical agenda. The unprecedented debate and attention given to nursing education curricula which surrounded the introduction of cultural safety illustrates further the struggle for nursing to position the nursing identity outside the dominant discourses of nurse and nursing. Moreover, since the 'truth' claims of cultural safety have been distorted through the media in particular, it is not difficult to imagine the difficulty in nurses exercising agency to adopt or act on it.

Chapter summary

This chapter, in describing and analysing the introduction of the notion of cultural safety into nursing education curricula, highlights what Shirley Grundy (1987) has identified, that is, that both curriculum and knowledge are social constructions which have meanings associated with social domination. The dominant view of nursing education in New Zealand is that it should be concerned with ensuring that nurses have technical or practical skills. The emancipatory activities of critical social science knowledge within nursing education curricula are misunderstood. This, it can be seen, adds to the difficulty of explanations about the purpose of cultural safety and its place in nursing education and nursing practice.

There is, however, a statutory requirement for nurses to be culturally 'safe' practitioners. The following chapter will provide an overview of the extent to which legislation and statute governs the identity of the nurse.

CHAPTER TEN

REGIMES OF REGULATION

Throughout this thesis, frequent reference has been made to the role of legislation in requirements for and changes associated with the education of nurses. In the preceding chapter, the introduction of cultural safety into nursing education curricula was a requirement of the legislative body which governs nurses and midwives. There can be no doubt that legislation which regulates the education of nurses was introduced in the early part of this century as a method of control over who could become a nurse, who was entitled to refer to themselves as a nurse, and the requirements for a particular nursing programme undertaken in order to become a nurse. The role of regulation in the practice of nursing, however, is less clear, but it seems that there is an expectation that the nurse will conduct herself in a particular way. Thus it appears that regulation in relation to nursing governs the nurse rather than the occupation of nursing.

The International Council of Nurses (1986) notes that regulation is concerned with the governance of occupations. What this chapter will analyse is how the influence of regulation on the nursing identity constructs the nurse in terms of a legal subjectivity, in which various discursive practices of the regulatory regime keep the nurse in a particular subject position. In an increasingly deregulated society, the introduction of professional and legally sanctioned codes of conduct as well as the specification of competencies, reinforce the position of the nurse as a legal subject. It is also argued that the discursive practices of these codes of practice have an effect of continuing to normalise the nurse through systems of surveillance as well as through examination. Nurses may not recognise that this helps to create a particular subjectivity through what Foucault (1988) refers to as technologies of the

self. In that the nurse is implicated in the creation of her own subjectivity, it becomes crucial to critique statutory regulation of the nurse in terms of how power is exercised, not within institutions but through less obvious means.

The purpose of regulating nurses

A brief examination of the purposes of regulating nurses provides a starting point for exploring the function of a statutory authority in the governance of nurses within the occupation of nursing. As identified in the introductory chapter of this thesis, it is an offence for any person to call themselves a nurse in New Zealand unless her or his name has been entered in the register or roll of the Nursing Council of New Zealand. This is because of the existence of the Nurses Act 1977 which governs the education and practice of nurses and midwives, where this is stated specifically (Nurses Act 1977, Section 52). The reasons for the regulation of nurses are essentially for the protection of the public from individuals who may call themselves nurses and thereby undertake activities associated with the provision of nursing care. A further reason is presumably to ensure that there is consistency or standardisation between and among a group of people who perform a particular function in society to members of that society. There is, therefore, a feature of control implicit in the notion of regulation. The International Council of Nurses makes this apparent in its publication *Nursing Regulation Guidebook: From Principle to Power* in which professional regulation is defined as "... the means by which order, consistency and control are brought to a profession and its practice" (Affara and Styles, 1992:7).

There are also dimensions of regulatory systems for nursing. These are specified as "... the purposes, objects, mechanisms, authorities, agents, standards, methods and instruments of regulation", (Affara and Styles, 1992:8), and a summary of these dimensions provides an overview of the complexity of nursing regulation.

- The *purposes* identify why the regulatory system is established. These may include any or all of the following: protecting the public from unsafe practices, ensuring the quality of services, fostering the development of the profession, the conferring of accountability, identity and status on the nurse, and promoting the socio-economic welfare of the nurse.
- The *objects* identify who is regulated or controlled by the regulatory process. This may include the practitioners, the providers of educational programmes and the actual educational programmes.
- The *mechanisms* identify what form regulation takes. This may be registration certification, accreditation, qualification or similar terms. However there is no universal definition of the notion of regulation.
- The *authorities* identify who authorises a regulatory system - usually the government through a process of enacting laws.
- The *agents* are the authorities of regulation and administer the regulatory process. This usually takes the form of a Nursing Council or Board of Nurses prescribed in law.
- The *standards* identify the measures of safety or quality required. These may be prescribed in law or they may be developed by the regulatory agent responsible for the registration of nurses.

- The *methods* or *instruments* identify the criteria for measuring the way in which the standards have been met. Examples of these include national examinations or acceptable assessment procedures, information from providers of nursing education programmes in relation to the programme, such as teaching staff. Further criteria relate to codes of conduct, and the disciplinary processes established for addressing breaches of defined standards.

These dimensions of a regulatory system can be seen in the regulation of nurses in New Zealand. As previously discussed nurses have been regulated in New Zealand since the enactment of the Nurses Registration Act 1901. The legal responsibility for the occupational governance of nurses was initially vested in the Registrar of nurses, and as discussed in chapter four, this was the Inspector-General of Hospitals within the Department of Health - a medical practitioner. With the enactment of the Nurses and Midwives Registration Act 1925, this governance role became the responsibility of the Nurses and Midwives Registration Board which was constituted under this Act, and the position of registrar was statutorily assigned to a nurse - the Director of Nursing in the Department of Health.

While the dimensions of occupational regulation outlined earlier from the work of Affara and Styles (1992) have been in existence in New Zealand for almost one hundred years, the emphasis in the early days of such regulation seems to be associated with controlling the requirements for nursing education programmes, where these programmes would take place, examinations, and entry to the register. Section 8 of the Nurses and Midwives Act 1925 illustrates this when it outlines the functions of the Nurses and Midwives Board to be:

- (a) To determine courses of training to be undergone by candidates for examination as nurses, midwives, and maternity nurses under this Act:
- (b) To approve hospitals at which approved courses of training may be received:
- (c) To conduct examinations under this Act; to appoint examiners and make all other necessary arrangements for the purposes of such examinations; and to issue certificates of having passed such examinations to persons entitled thereto:
- (d) To receive applications for registration under this Act; and to authorize registration in cases where the conditions of registration have been complied with:
- (g) Generally, within the scope of its authority, to do what ever may in its opinion be necessary for the effective administration of this Act.

Little has changed since 1925. A board has been replaced by a Nursing Council, the functions of which are outlined in the Nurses Act 1977; these are essentially similar to those outlined above in the 1925 Act. Despite this Act having two amendments since its enactment (1983 and 1990), little has changed in terms of occupational governance from a statutory perspective. But more importantly, while this legislation is in existence, it is only the Nursing Council of New Zealand which has the authority to register nurses in New Zealand. As discussed in chapter eight, although the New Zealand Qualifications Authority appears to have some overlapping functions with the Nursing Council as result of the enactment of the Education Amendment Act 1990, these are in terms of curricula and course requirements, rather than with the notion of registration. It appears, therefore, to be the matter of registration that is at the essence of governance of a particular individual or group of individuals. The governance of nursing is a consequence of defining who can be a nurse.

The registration of nurses in New Zealand came about in a relatively uncontested way. The enactment of the Nurses Registration Act 1901 was significant, in that New Zealand was the first country in the world to enact such a statute. Some confusion exists here in that it is sometimes asserted that New Zealand was the first country in the world to register nurses and to establish minimum standards for their training. Nurses in South Africa (Cape Colony) in 1891 were registered when provision was made for a standardised course of training and registration in a section of the Medical Practitioners and Pharmacists Act of 1892 (Dock, 1912; Styles, 1986; Searle, 1988). It is the enactment of a separate Act for the registration of nurses that New Zealand did first.

A further purpose of having a register was for the publication of the names of registered nurses, although as Wilson (1995) claims the real reason for registration of nurses was to provide medical practitioners with a list of qualified nurses to complement their practice. Jan Rodgers (1985) notes that commencing in 1903, the *Gazette* provided details of names, addresses and training schools of nurses, and differentiated between those who registered through practical experience (refer to chapter four) and those who had undertaken the state examination. The publication of names was for the protection of the public as well as doctors from incompetent persons.¹

Nurses and Nursing

The Nurses Act 1977 defines what a nurse is but does not define the practice of nursing. As Styles (1982) identifies, there is no universal definition of nursing. It appears then, that no one can be prevented (by statute at least), from using the term *nursing* to describe may be being done in the provision of a particular activity which

¹ The publication of this list of details of registered nurses (first called trained nurses) continued until 1932.

might be some form of care for another person. To be noted is that the legal restriction on the title of nurse seems to refer to a person using such a title to suggest that he or she has a qualification to practise nursing. That is, the offence associated with this seems to be more directed at the fraudulent use of the title of nurse rather than preventing anyone from practising what may be called nursing. This is not the case with medical practitioners where the legislation explicitly states that practising medicine without being registered as a medical practitioner is the actual offence (Medical Practitioners Act, 1995, Section 7). So despite the existence of a statute which purports to protect the public from unqualified persons, it seems that what it is that nurses do and which is called the practice of nursing is something that anyone, or indeed everyone, can do as long as they do not refer to themselves as a nurse.

This then, raises the question of what occupational regulation actually does. It can be argued that it exists simply to determine who can or can not be a nurse, either through entry to the register in the first instance by meeting specified standards, or being removed from the register by not meeting specified standards. In terms of the practice of nursing, an important issue arises here in relation to the attainment of a degree in nursing. The ability of polytechnics to confer the qualification of degree could result in a possible scenario where an individual completes the requirements for a degree within a polytechnic course but does not meet the requirements of the Nursing Council of New Zealand for registration. If it is the title of nurse and not the activity of nursing that is regulated, then ostensibly, an individual could set themselves up in practice to provide nursing care if they have, for example, a Bachelor of Nursing degree but do not refer to themselves as a nurse. Thus the legal subjectivity of the nurse is contingent upon the notion of registration.²

2

In the case of enrolled nurses, legal status is contingent upon enrolment as a nurse.

This issue is presently compounded in New Zealand where the majority of nursing students undertake the State Examination of the Nursing Council of New Zealand in November of each year, but graduate from their particular polytechnic course before the results of this examination are available. Since the Nurses Regulations 1986 prevent an individual from attempting the State Final Examination more than three times (Nurses Regulations 1986, 18 (5)), there could be a situation where an individual is the holder of a degree in nursing but does not in fact obtain registration. Occupational regulation in terms of registration or certification seems, therefore to protect the title 'nurse'. One solution to this potential dilemma would be abolishing the State Examination, so that on completion of the nursing course, registration requirements are also met. However, the existing legislation prevents this. As identified in chapter eight, the State examination of the Nursing Council of New Zealand is in essence the final arbiter in determining who can become a registered nurse. The notion of "examinable competence" (Chua and Clegg, 1990) continues to be a major determinant in the education of nurses. However, it is not the only determinant. In order to be admitted to the Register of Nurses, each person seeking to be registered as a comprehensive nurse has to comply with the legislated requirements prescribed in the Nurses Act 1977 and its amendments and the Nurses Regulations 1986, as well as the requirements of the Nursing Council of New Zealand's policy and guidelines.³

The legislative requirements have been translated into a policy document which states the specific requirements defined within various parts of the Nurses Act and Nurses Regulations. This means that each applicant:

³ This is also a requirement for those applicants to the register of midwives and the roll of nurses.

- has achieved the expected outcomes of the course
 - is currently competent and safe to be registered as a comprehensive nurse in any New Zealand setting
 - is fit and proper to be registered as a comprehensive nurse
 - is of good character and reputation
 - achieves a pass in the State examination for comprehensive nurses
- (Nursing Council of New Zealand, 1996c).

The first four criteria are required to be met before an applicant can undertake the state examination for comprehensive nurses. Written applications to undertake the state examination are made through the institution in which the course was completed, and the meeting of these criteria is attested to by the head of the nursing department in each polytechnic. In terms of the criteria for 'fitness and properness' and "character and reputation" each applicant provides the names of two referees from whom references may be sought by the Nursing Council. However, these terms seem to relate more to criminal activity for which an applicant may have been convicted. Declaration of any conviction (other than 'minor traffic offences') is a mandatory part of application to undertake the state examination (Nursing Council 1996c).

For the year ended 31 March 1996, fifty-nine applicants for registration declared a total of 81 court convictions. It is worth examining these in order to provide a picture of what may affect the 'fitness and properness' and 'character and reputation' of an applicant for registration.⁴ It is noted that the convictions were for:

⁴ The notion of 'character and reputation' first appears in the Nurses and Midwives Act 1925. 'Fitness and properness' first appears in the Nurses and Midwives Act 1945.

drink driving (17) various driving/vehicle offences (14) theft (11) possession of marijuana (8) underage drinking (4) theft as a servant (3) assault (2) shoplifting (2) fraud (2) failure to notify Social Welfare of a change in circumstances (2) and a variety of other offences, including wilful damage, trespass, breach of probation, possession of a firearm, signing a false statement, disorderly behaviour, using a document for advantage, littering, unlawfully aboard a ship, not filling out a declaration correctly, breach of court bail, failure to declare income (Nursing Council of New Zealand, Annual Report, 1996d)

In all of these situations the Nursing Council was satisfied that the requirements of regulation 19 (a) of the Nurses Regulations 1986 had been met, and the candidates were able to sit the state examination. The point that is being made here is that there is an ongoing statutory requirement for a nurse to be a person of 'good character' - whatever that means. Only the Nursing Council has the ability to make that decision in this regard.

Legal status and professional obligations

It has been identified earlier (refer to chapter one), that nurses have a mandate from society to perform a particular function - nursing. This right is bestowed on nurses by the State. Nurses in New Zealand have a legal right to perform the function of nursing through their registration or enrolment with the Nursing Council of New Zealand and the holding of an annual practising certificate which confers on each nurse responsibility and accountability for her/his practice. Having a current practising certificate is an essential requirement in order for a nurse to practise nursing. As the Nurses Act 1977, Section 51 (2) specifies: "No person registered or enrolled under this Act shall in any year be entitled to practice the calling in respect of which he is registered or enrolled unless he is the holder of an annual practising certificate..."

In fact it is an offence for any nurse to practise without a current practising certificate (Nurses Act 1977, Section 51 (3)). Ironically, however, the holding of an annual practising certificate is, in effect, only evidence that a practitioner's name is on the register - or roll in the case of enrolled nurses. There is no corresponding requirement for any demonstration of current competence to practise nursing. Nurses or midwives who may not be practising either nursing or midwifery, on the payment of a fee, can simply renew annually, their annual practising certificate whether or not they have currency of practice. On the reverse side of each annual practising certificate issued, however is a statement which reads: "The holder of this certificate is responsible for practising in terms of the nursing legislation and for upholding professional standards of nursing practice".⁵ Thus it is clear that the responsibility and accountability for safe and competent practice rests with the practitioner even though there is no specific legislated requirement for this.

The Nursing Council of New Zealand is, however, presently undertaking a project to address this perceived anomaly with the intention of linking the renewal of a practising certificate to current competency to practise. However, as the Nursing Council points out, legislative change is necessary before this can happen, since there is no provision in the existing Nurses Act 1977 to require any demonstration of competence to practise (Nursing Council of New Zealand, 1996). There is a clear intention to have this requirement enshrined in legislation outlined in the current review being undertaken of the Nurses Act 1977 (Ministry of Health, 1996), and it is supported by the Nursing Council of New Zealand. Proposed changes to the legislation which regulates nurses and midwives in this regard is planned to follow the framework of the recently enacted Medical Practitioners Act 1995 (Ministry of Health, 1996).

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The writer's annual practising certificate is the source of this information.

An important question therefore, is what difference will introduction of 'competency based practising certificates' make to the public if a nurse can only have a such a certificate renewed on the basis of demonstrating competence to practise when there is no statutory definition of nursing practice and anyone can carry out nursing? The lack of any specified statutory requirement to maintain competency places an onus on the nurse (or midwife) to maintain currency of knowledge and practice. However, the right to be called a nurse or midwife carries with it particular obligations, such as a duty of care which includes the provision of safe and competent care. In relation to the notion of 'duty', from a criminal perspective the Crimes Act 1961 clearly applies to nurses who are responsible for the care of patients. This is made clear in Section 151 (1) of this Act, which states

Everyone who has charge of any other person, unable, by reason of detention, age, sickness, insanity, or any other cause, to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (whether such charge is undertaken by him under any contract or is imposed upon him by law or by reason of his unlawful act or otherwise howsoever) under a legal duty to supply that person with the necessaries of life, and is criminally responsible for omitting without lawful excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured by such omission.

Given that the education of nurses is to prepare them to function in a variety of health care settings it is to be expected that nurses will encounter situations in which they are providing care for patients with high dependency needs (Burgess, 1993). In addition, a conviction of a nurse for failing to provide the 'necessaries of life' or, as defined in Section 151 (2) of the Crimes Act 1961, 'neglect of duty' can result in imprisonment for a period of up to seven years.

There is a requirement in the Crimes Act 1961 (Section 155) in terms of the duty of persons doing dangerous acts to use "... reasonable knowledge, skill and care in

doing such any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty". The acts that are defined as dangerous in this section include the administration of medical or surgical treatment - which many nurses undertake on a daily basis in the course of their work. The point being emphasised here is that it would seem that there is already a plethora of provisions which make nurses accountable for their actions, without the need to have another set of criteria which must be met in order to demonstrate competence and safety to practise.

The introduction of mandatory demonstration of competence illustrates how power is exercised in relation to the legal subjectivity of the nurse. Following the ideas of Foucault (1977) it can be argued that the effect of mandatory competence will be to increase surveillance of nurses. Through the establishment of a set of requirements nurses will be required to demonstrate that they have achieved, there will be normalising judgments made about 'the competent nurse', thus the exercise of power through technologies of domination is evident. Since both the *Code of Conduct* published by the Nursing Council of New Zealand in 1995 and its competencies developed in 1996 for applicants for registration make it very clear that there is a personal responsibility for ongoing professional development, it seems unnecessary to be promoting a statutory provision for the demonstration of ongoing competence to practise nursing. Also, the New Zealand Nurses Organisation (1995) has a published *Code of Ethics* which identifies an expectation for nurses to conduct themselves in a particular way. Hence it can be seen that what is produced through this governing activity are what Johnson, (1993:144) refers to as "individuals, highly trained and socialised in accordance with an agreed ethical and disciplinary code". Chapter eleven further explores how power is exercised in self surveillance, which involves nurses in the creation of their own subjectivity through practices or technologies of the self (Foucault, 1985).

Professional or improper conduct

The governing or, to use Foucault's term, the governmentality of the nurse as a legal subject is reinforced through processes of normalisation and surveillance as a form of disciplinary power (Foucault, 1977), and aligns the subject with the norm. In addition to breaches of duty perceived as criminal acts, if a complaint is made to the Nursing Council that a nurse does not meet a particular standard of care, that is in accord with the 'norm', the disciplinary provisions of the Nurses Act 1977 can be invoked. These provisions are significant to later discussion in this chapter about the notions of profession and professionalisation. It appears that legally, nursing has to be considered within the broad notion of professional status because of legislation to regulate who can or can not be called a nurse. And because of that legal status, there is a corresponding power that a statutory body has - in the case of nurses the Nursing Council of New Zealand - which maintains a standard of practice or professional conduct for nurses.

It can also be noted that there is some variance in the way that the disciplinary processes and the conduct of nurses have been outlined in nursing legislation. Although the Nurses and Midwives Board had a statutory disciplinary function, its powers in respect of disciplinary processes are not identified within its functions, but are located elsewhere in the 1925 Act (section 21 & 22). The reasons for this are not obvious, but it may be that the main concern of the legislated functions of the Nurses and Midwives Board were with education and admission to the register rather than with disciplinary functions. Moreover, the number of disciplinary activities undertaken by the Nurses and Midwives Registration Board and its successor, the Nurses and Midwives Board established in 1946, is unclear. ⁶

⁶ The Nurses Act 1971 specifies in Section 3(3) that the records relating to the registration of nurses which could be defined as public records under the Archives Act 1957 which were in the possession of the Department of Health at the time of the establishment of the Nursing Council of New Zealand were to be transferred to this body. However, it is difficult to

The earlier legislation did not refer to professional misconduct, but rather specified other aspects of conduct. In the Nurses Registration Act 1901, the term *grave misconduct* was used. The disciplinary provisions of the Nurses and Midwives Act 1925 were concerned with a nurse who may have been "... guilty of such *improper conduct* as renders her, in the opinion of the Board, unfit to be registered under this Act. The Nurses and Midwives Act 1945, Section 33 outlined two aspects of conduct: "... gross negligence or malpractice in respect of his calling... (and) ... grave impropriety or misconduct whether in respect of his calling or not". Additionally, in all of these iterations of legislation, the disciplinary powers were such that any conviction could see a nurse's name removed from the register.

It was with the enactment of the Nurses Act 1971 which established the Nursing Council of New Zealand that the disciplinary powers of the Nursing Council were embodied in the section which outlined its functions. The disciplinary powers outlined in the Nurses Act 1977 Part 1V address the matter of complaints against nurses and the subsequent processes of inquiry and investigation that the Nursing Council is empowered to conduct. The ultimate purpose of such investigations is to determine whether or not a nurse about whom a complaint has been made is guilty of what is no longer now in respect of the nurse's "calling" but rather *professional misconduct*. Section 2 of the Nurses Act 1977 defines professional misconduct as:

Conduct which in the judgement of the Council, -

- (a) Amounts to malpractice or negligence by that nurse in relation to the class of nursing in respect of which he is registered or enrolled; or
- (b) Brings or is likely to bring discredit on the nursing profession.

determine the exact location of some of the records of disciplinary activities carried out by the Nurses and Midwives Registration Board and its successor, the Nurses and Midwives Board.

These provisions clearly exist in terms of public safety. It is worthy of comment, however, that until the enactment of the Health and Disability Commissioner Act (1994) there was no corresponding provision to address the perceived wrongdoing of any person who was not a health professional such as a nurse or medical practitioner, other than the provisions of the Crimes Act 1961. The Health and Disability Commissioner has developed, and in July 1996 published, a Code of Health and Disability Services Consumer Rights,⁷ breaches of which by a nurse may ultimately result in disciplinary action by the Nursing Council. The provisions of the Nurses Act 1977 continue, however, in terms of complaints about the professional misconduct of nurses. In one sense then, it can be argued that nurses are extremely governed, regulated and controlled by the State through at least three different pieces of legislation. The legal status of the nurse can be seen to have a corollary of obligations, and a duty to care without the statutory imposition of further demonstrations of competency. It needs to be considered that there is seen to be a need to demonstrate that what nurses in the practice of nursing do is different from what non-nurses do.

In the view of Megan-Jane Johnstone (1994:22) nurses have not achieved a level of professional status which matches their legal responsibilities as practitioners. Nurses are accountable and responsible for their practice, yet despite this, there are limitations on their practice in terms of what may be termed professional judgements in relation to prescribing aspects of patient care. It is the medical practitioner (within a hospital environment anyway) who has the legal authority to do this. The boundaries between what is nursing judgement and medical judgement are rather blurred. What is clear, however, is that in the event of any suggestion of

⁷ These have been promulgated through the Health and Disability Commissioner Act 1994, and now exist in statute as The Health and Disability Commissioner (Code of Health and Disability Rights) Regulations 1996.

negligence or malpractice in relation to an issue of patient care, the action a nurse may have taken (or omitted to take), and similarly, with a medical practitioner who may be involved in the care of a particular patient, it is carefully tracked to determine culpability in the event of a perceived wrongdoing.

Since the legislation specifies the conduct of nurses as 'professional' it is important to ascertain what this actually means in terms of the identity of the nurse and nursing as an occupation. This requires discussion about the notions of profession and professionalisation.

Professionalism

There are many definitions of profession and professionalism, and many arguments about what the criteria are for a particular occupation to be termed a profession. Friedson (1970) suggests that a profession should be regarded as a description of a type of occupational control. Bledstein (1976) examined the increase in the number of skilled occupations resulting from industrialisation during the nineteenth century. He argues that embracing professionalism was a strategy that elevated the prestige and status of the work of particular occupational groups and enhanced remunerative potential. The professions were defined during the nineteenth century in terms of occupations considered to offer suitable work for gentlemen. Divinity and law were such examples; medicine was also able to aspire to such status (Freidson, 1970, Hughes, 1990). Power relationships are seen to be at the essence of the caring professions within which nursing is seen to be positioned by Richard Hugman (1991:1) who asks

To what degree, and in what way are caring professions produced through power relationships at both the interpersonal and the structural levels. In what way do issues of power relate to the historical development and contemporary structures of caring professions?

Professionalism is most frequently approached from a sociological perspective. Alistair Campbell (1984:2) identifies that three main approaches include "... the trait approach, the power approach and the functionalist approach". He suggests the trait approach is a "dead end" in that it attempts, through a list of traits, to differentiate a professional occupation from any other occupation. The list includes matters of recognised training, the length of which is several years; ways in which competence is able to be tested, and members of the occupation are subject to disciplinary processes by the occupational group itself; a 'professional ethic' or service orientation, and a body of 'power and skill'. The listing of traits or features in this way is seen to be problematic in that it is static and does not account for any evolution or change within the concept of professionalism itself. In addition, the criteria are wide enough to consider almost any occupation to be determined a profession. But at the same time the criteria can also exclude some occupational groups because they lack occupational independence (Campbell, 1984).⁸

The "power approach" emphasises the status and privileges achieved through a monopoly of work which is enforced through Registration Acts and autonomy and control in terms of training, accreditation and selection of members of the occupational group. Medicine is used as an example (Campbell, 1984). The functionalist approach addresses the way in which occupations practice in terms of being socially useful. Two key aspects are identified as 'trustworthiness' - where the recipient of a service is considered to be physically or emotionally vulnerable - and affective neutrality' - a term which implies that there is a need for emotional

8 Campbell gives nurses as one of two examples of occupations which lack occupational independence. This highlights the perception that nurses must always be employees. There is nothing to prevent nurses setting up as independent practitioners, and in fact in New Zealand at present there are several independent nurse practices. The issue seems to be one of funding rather than occupational dependence on others.

distance from the recipient of the service (Campbell, 1984). In general, medicine's practices and institutions have significantly influenced the criteria for professional definition, since it is seen as the paradigm profession (Hoyle and John, 1995).

A literature review conducted by Whittington and Boore (1988) provides a useful summary of professionalism for the purposes of discussion in this chapter. They suggest that the characteristics of professionalism can be identified as

- Possession of a distinctive domain of knowledge and theorising relevant to practice.
- Reference to a code of ethics and professional values emerging from the professional group and, in cases of conflict, taken to supersede the values of employers or governments.
- Control of admission to the group through the establishment, monitoring and validation of procedures for education and training.
- Power to discipline and potentially debar members of the group who infringe against the ethical code, or whose standards of practice are unacceptable.
- Participation in a professional sub-culture sustained by formal professional associations (Whittington and Boore, 1988:112).

Given the discussion so far in this thesis, it could be argued that the educational requirements to become a nurse and the practice of nursing show that these criteria are met. Previous suggestions that nursing is not a profession, such as Etzioni (1969) could be regarded as outdated, given changes in nursing education and nursing practice. The debate about nursing's professional status or otherwise can also be seen to be concerned with whether or not nursing has a 'body of knowledge'. As Hoyle and John (1995) assert, studies of professions identify that a recognised body of knowledge is an important criterion in the categorisation of an occupational group as professional. They claim that it is this body of technical or specialist knowledge which is beyond the reach of a lay person that forms the basis

for a profession's practice. This knowledge has been seen as having two essential components. Firstly, it has been tested by a scientific method which ensures validity, and secondly, there are a variety of theoretical models which support it. As discussed in chapter seven, knowledge viewed in this way is considered 'truth' only if it fits within the positivist tradition in terms of its creation.

Nursing and the dominant professionalism discourse

The issue of knowledge is an important consideration which impinges on perceptions of nurses as professionals and nursing as a profession. Significant in this respect is the interrelationship between knowledge and gender. As identified in chapter seven, the issue of knowledge and ways of knowing are crucial to nursing education and nursing practice, and the positioning of nurses in the health care system. Recent writers in the area of professionalism have identified gender issues as significant in the notion of professionalism, and it is useful to examine some of these views.

Melia (1987) suggests that nurses use the term 'profession' to refer to professional conduct, which implies 'professional etiquette' rather than status or autonomy of practice. She suggests that nurses are unclear what they mean by the term 'professional'. Linda Hughes (1990) suggests that nursing has tried to blend two conflicting roles of an occupation that are irreconcilable. The issue of nursing, seen as women's work, and the issue of professionalism, she claims, highlights the tensions between nursing's difficulty in being considered as a profession.

As Davies (1995) argues, however, even though the thinking about professionalism in nursing may be changing, the issue of gender has not been fully confronted. She claims that professionalism needs to be informed by a model of caring, but cautions that in order for this to happen, there must be better understanding than is

articulated at present of “what it is to care and of the different contexts in which caring occurs” (Davies, 1995:134). She asserts it may be more beneficial in the long term for nursing to challenge the gendered notions of professionalism which fail to acknowledge the knowledge inherent in the notion of caring than to seek professional status.

But it can also be argued that nurses have sought to have nursing defined as a profession within the structures, processes and ideology of patriarchy, which has been unproductive in developing a counter discourse by which to resist the dominant definition of professionalism (Dickson, 1993). There are undoubtedly other ways of viewing the notion of professionalism, which are as relevant as any metanarrative definition of the notion of professionalism. Nursing may be no more or no less a profession than any other health occupation.

Professionalism and professionalisation, however, are discourses which clearly have their own discursive practices. Chua and Clegg (1990) identify four different discursive themes in which the nurse has been constructed, and each of these identify the notion of a “professional” nurse. They note that in the Nightingale era, the notion of a professional nurse was associated with the womanly virtues of subservience, morality, discipline and vocation. The notions of vocationism, examinable competence, as well as segregation through registration was a feature of the professional nurse during the period 1900 to 1939. From this time until 1966, they note that vocationism and examinable competence continued, but that segregation was now apparent through division of labour process. A period of managerialism, bureaucracy and the creation of knowledge, they claim, has been evident since 1966 (Chua and Clegg, 1990). These features are apparent within nursing in New Zealand.

A difficulty for nursing in arguing to be a profession in relation to the development of nursing knowledge, is that scholarly activity seems to become secondary to pursuits of industrial claims for increased status and salaries and career structures for those nurses who are employees. The role of the New Zealand Nurses Organisation has been pivotal in this regard. It can be argued that creating resistance to dominant discourses may be done in another way than arguing for conditions of work, in terms of the interrelationship between knowledge and skills, which makes nurses what Antrobus (1997) refers to as "knowledge workers". According to Abbot (1988), professions are bound to sets of tasks, which are controlled by that group. This means it is the work that a profession does that is its essence. He explains

The tasks themselves are defined in the profession's cultural work. Control over them is established by competitive claims in public media, in legal discourse, and in workplace negotiation. A variety of settlements, none of them permanent, but some more precarious than others, create temporary stabilities in this process of competition (Abbot, 1988:84).

In having two levels of nurses, that is registered and enrolled nurses, nursing has not clearly articulated the difference in the nature of nursing practice between these two groups (Dixon, 1996). As a result there is an emphasis on what the nurse *does*, rather than what the nurse *knows*, and how this is relevant to nursing practice. Attempts to differentiate one group from another are also seen to be associated with the notion of professional closure. This concept is a sociological explanation for the limitation of membership of a particular group or occupation. Raymond Murphy (1984) identifies two methods of closure - exclusion and usurpation. In the case of exclusionary closure, power is exercised in a downward direction. A process of subordination takes place whereby one group secures its advantages over another group and defines this subordinate group as inferior. Usurpationary closure means that power is exercised in an upward direction. The group which perceives itself as

disadvantaged attempts to obtain the status and prestige of the perceived powerful group. This results in a counter struggle by the excluded group in an attempt to overcome dispossession, loss of self-esteem and subjection (Murphy, 1984).

As chapter four illustrated, the medical profession was influential in perpetuating medical and gender discourses in which the nurse became positioned as a docile body. The notion of professional closure can be seen to be appropriate for viewing how nursing became established in New Zealand and how a legal status was created for the nurse through regulation. Subsequent changes to systems of nursing education can be considered as a counter struggle from the perspective of exclusionary closure to exclude untrained individuals from their ranks.

Professional closure and the enrolled nurse

There is some similarity with the concept of professional closure and the points Foucault addresses in his 'analytics of power'. The power relations in which nurses are enmeshed, in particular through "systems of differentiations" (Foucault, 1982), exemplifies how occupational regulation sets one group apart from another. An amendment to the Nurses Act 1977 in 1983 provides the most salient example of this in terms of the enrolled nurse. In this legislative change, a section was inserted into the substantive Act (Section 53A), which stated

Every enrolled nurse commits an offence and is liable on summary conviction to a fine not exceeding \$1000 who, other than in an emergency, practises nursing other than under the direction and supervision of a registered nurse or medical practitioner.

The significance of this is that for the first time in the history of nursing the enrolled nurse was separated from the registered nurse in terms of scope of practice. The reasons for this direction and supervision requirement were stated to be because the

training of enrolled nurses was a one year hospital based programme which entailed some eight weeks of theory with the remaining time 'learning' in the clinical environment. With the transfer of nursing education into the tertiary education sector and the consequential reconfiguration of the nursing workforce to gradually replace student nurses with qualified nursing staff, in some situations enrolled nurses were being utilised beyond the scope of their practice (New Zealand Nurses Association, 1984). The intended effect of this statutory difference was not straightforward, since there was no clear definition of the notion of supervision. In addition, the fact that enrolled nurses could practice nursing under the supervision of a medical practitioner negates any apparent difference in the scope of practice between registered and enrolled nurses. However, it can be argued that for enrolled nurses in New Zealand, it represents exclusionary closure, in that they were legally restricted in respect of nursing practice.

That this professional closure, or differentiation of enrolled nurses from registered nurses occurred, possibly had the potential for nursing to lay claim to professional status through reinforcement of the difference in knowledge between these two groups of nurses. That challenge has never been taken up.⁹ The position of the enrolled nurse is tenuous in nursing in New Zealand. It is complicated, not least by the legal subjectivity of this group of nurses, but also by the perceived need for two levels of nurse to exist in the provision of nursing care in the health system (O'Connor, 1995). It may be addressed through the present legislative agenda presently reviewing occupational legislation in New Zealand, which seeks to have enrolled nurses deregulated (Ministry of Health, 1997).

⁹ For a detailed discussion about the current situation in relation to the future of enrolled nurses in New Zealand, see Dixon (1996).

The relationship between the notions of profession and professionalism can also be viewed in relation to Foucault's concept of governmentality. Gordon (1991:2) defines this as "a form of activity aiming to shape, guide or affect the conduct of some person or persons". The nominalist position of Foucault means that his interest is not with who owns or can lay claim to power, but rather that only when a relation of power exists, and when it is exercised, then it exists. Thus his concern is to view the outcome of power not as a relationship of domination, but that the normalised subject will be obedient. It is this that reproduces the legitimacy of power (Johnson, 1993). In this regard, a statutory regulatory authority, such as the Nursing Council of New Zealand is part of a machinery of government which serves to govern the nursing identity by a "very specific albeit complex form of power" (Foucault, 1979:19). In that nurses are defined by statute as a particular type of 'expert' with expected ways of acting and behaving, and are subjected to the specifics of professional codes, they are shaped by the notion of professionalism, whether or not nursing is referred to as a profession. Like other regulated occupations, they produce subjectivity in terms of a subject who is subjected in the sense that Foucault uses this concept.

In summary, this chapter has argued that the nursing identity is clearly governed through occupational regulation to behave in a particular way. Governance implies a governable individual. However, Foucault's view of power suggests that there is more to the notion of governance than simply seeing it in terms of sovereign power. Foucault's notion of governmentality, is linked with processes of normalisation, which establishes, institutionalises and disciplines. This lays the ground for the autonomous, self-regulating subject. In the next chapter, this will be explored through Foucault's (1985) insights into the "practices of the self".

CHAPTER ELEVEN

CARE OF THE SELF AND CARE OF THE SICK

Foucault's notion of the 'docile body' was utilised in chapter four to provide a perspective by which to examine the effect of the Nightingale ethos on the construction of the nurse and its continued influence on nursing education and a particular nurse identity for some seventy years of nursing education in New Zealand. The discursive constitution of the nurse within the discourses of gender and medicine has been explored in subsequent chapters, through an analysis of curricula and knowledge. For Foucault, the notion of the docile body is an effect of technologies of domination, which he postulated as one way of how power is exercised in the creation of subjectivity. But these are not the only technologies of power. Foucault (1988) also refers to technologies of the self - that is, practices of surveillance, correction, and improvement to an obedience maintained through self-policing - as a means of identifying how individuals are implicated in the creation of their 'self'. These technologies of the self require further examination in relation to particular aspects of the educational process of the nurse and the construction of the nurse identity within a different network of power relations. It will be argued in this chapter that the identity of the nurse is as much shaped through technologies of the self as it is through technologies of domination. That is, the nurse implicates herself in the creation of her identity as a nurse.

To illustrate the effect of technologies of the self, the focus of this chapter is on three concepts which are emphasised in nursing education curriculum requirements. Reflection and caring have become part of nursing language, and represent essential properties of the 'modern' nurse. More recently, as identified in chapter nine, cultural safety has been introduced into the ethos of nursing, and this notion also

represents part of the professional armature of the nurse. In this chapter these themes are considered in the Foucauldian sense of discourses, and are analysed in terms of how the nurse is discursively constituted within these, through processes which Foucault (1985) refers to as “practices of the self”.

Each of the discourses analysed in this chapter has its own discursive practices.

Foucault (1972:117) identifies that a discursive practice is

A body of historical rules, always determined in the time and space that have defined a given period and for a given social, economic, geographical, or linguistic area, the conditions of operation of the enuciative function”.

Additionally, Foucault points out that discursive formations are

not purely and simply ways of producing discourse. They are embodied in technical processes, in institutions, in patterns for general behaviour, in forms for transmission and diffusion, and in pedagogical forms which at once, impose and maintain them (Foucault, 1980:200).

Both discourses and discursive practices are thus considered to be relative to place and time. What is said, written and accepted, changes over time. Since these practices, as Foucault (1980) points out, refer to the way in which reality is represented and thought about - shaped by the relationship between power and knowledge - technologies of the self can be considered as a feature of self government. Thus although the nursing identity is governed by law in the sense of a legal subjectivity defined through the Nurses Act as discussed in chapter ten, technologies of the self also construct the nursing identity.

Burchell et al (1991) note that for Foucault, construction of identities involves a set of highly politicised activities, and that he used the term 'governmentality' in an interchangeable way with government. Foucault (1982) uses this term to represent a "contact point" between technologies of domination, in which normalising judgements, measurement and examination are key elements, and technologies of the self, which involves self surveillance and correction, designed to correct and improve. He asserts that governmentality is the "conduct of conduct", in which two meanings can be seen. One is concerned with being conducted, in much the same way as he refers to the notion of being subjected. The other meaning is a person's own behaviour or conduct.

The relationship of technologies of the self to the conduct of an individual is made apparent by Foucault 's definition of technologies of the self, which, he claims

permit individuals to effect by their own means or with the help of others a certain number of operations on their bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988:18).

Technologies of the self, then, according to Foucault (1988), represent procedures that are either prescribed or proposed to individuals as they maintain, fix or transform their identity with a particular end in view. For the nurse, the discourses of reflection, caring and cultural safety provide what Hollway (1984) and Weedon (1987) refer to as subject positions, in that they define what is a 'good' nurse, hence locating the nursing identity in a particular subject position into which to be transformed.

Foucault's ethics of the self

Technologies of the self need to be understood in relation to Foucault's notion of "ethics of the self". Foucault (1984:50) claimed that "... the critical ontology of ourselves ... has to be conceived as an attitude, an ethos, a philosophical life in which the critique of what we are is at one and the same time an historical analysis of the limits that are imposed upon us and an experiment with the possibility of going beyond them". In other words, Foucault's approach to ethics of the self is based on an ethic of who we are said to be, and what it is possible to become, rather than being based on adherence to externally imposed moral obligations (McNay (1994:145). Moreover, as Foucault (1988:6) reminds us, "(o)ne must not have the care for others precede the care of the self". The care for self takes moral precedence in the measure that the relationship to self takes ontological precedence". Foucault believed, then, that in practices of the self all knowledge is subordinated toward the end of practical self-mastery, and in response to a question in one of his final interviews he affirms this (Rabinow, 1980:369).

Foucault thought of ethics as a component of morality that was concerned with the self's relationship to itself. He argued that careful attention should be paid to the history of moral subjectification, and in this way differentiates morality from ethics. In Foucault's view, morality represents rules of conduct; ethics represents the way in which individuals live within those rules, thereby constituting themselves as moral subjects. His work within *The Use of Pleasure* (Foucault, 1985) which is concerned about ethical practices illustrates his differentiation between morality and ethics. He says

the history of morality has to take into account the different realities that are covered by the term. A history of “moral behaviours” would study the extent to which actions of certain individuals or groups are consistent with rules or values that are prescribed for them by various agencies. A history of “codes” would analyze the different systems of rules and values that are operative in a given society or group ... a history of the way in which individuals are urged to constitute themselves as subjects of moral conduct would be concerned with the models proposed for setting up and developing relationships with the self, for self-reflection, self-knowledge, self-examination for the decipherment of the self by oneself, for the transformation that one seeks to accomplish with oneself as an object (Foucault, 1985:29).

Within the general notion of practices of the self proposed by Foucault (1985), it is possible to examine the way in which individuals come to understand themselves within the particular context of socially and culturally constructed views of identity (McNay, 1994). Foucault (1985:26-27) suggests there are four elements to be considered in the relationship of the self to itself. First, “determination of the ethical substance” - the way in which an individual constitutes particular parts of her/himself as the material of his conduct. Second, the “mode of subjection” which is concerned with the establishment of an individual’s relationship with a particular rule or code in the sense of recognising an obligation to put it into practice. Third, the ethical work, or the forms of self-forming activity and its methods and techniques. And finally, is what Foucault refers to as the *telos* - the mode of being in which the ethical practice is situated. Thus it can be seen that there are four dimensions to an analytic of practices: an ontology - what it is an individual seeks to govern in self and others through a particular practice, a deontology or what is sought to be produced in self and others, an ascetics, which is concerned with how this element is governed, and its teleology, or what the aim of these practices is (Foucault, 1985:37).

In terms of the discourses of reflection, cultural safety and caring, Foucault’s technologies of the self provides a means by which to examine the constitution of the nurse identity. These discourses in their own way are hegemonic since they

represent the dominant view of those nurses who seek to define and describe what a nurse is (a competent, caring, self-aware individual) who attains this identity through a process of reflection. Foucault's term "care of the self" (1984) is useful in exploring how the nurse identity has moved into a space where knowing herself and reflecting on her practice as a nurse has a corollary of self-monitoring. Foucault's (1988) notion of technologies of the self relates to the ascetics dimension of practices of the self, that is the activity a person performs on self in order to be transformed into a particular subject, and is apparent in the form of listening, dialogue, self-examination, confession and so on. Thus the nurse is not only subjected to institutional surveillance, measurement and normalising judgements which represent technologies of domination, but also subjected to self surveillance, which with its own discursive measurement and normalising judgements, constitutes the nursing identity through technologies of the self. The nurse therefore remains within a network of power/knowledge relations in which a particular subjectivity or identity is constructed.

Reflection and reflective practices as technologies of the self

Within the last ten years or so nursing education and practice have adopted the notions of 'reflection' and 'reflective practice' as an important part of nursing. Recently the Nursing Council of New Zealand (1996c) has included reflection within its *Standards for Registration of Comprehensive Nurses* within one of eleven competencies to be demonstrated as part of the process of attaining registration as a nurse. The requirement of this particular competency is concerned with what is defined as 'professional judgement', and states that "(t)he applicant makes professional judgements that will enhance nursing practice". In order to demonstrate competence in professional judgement, the applicant:

- Makes nursing judgements based on current nursing knowledge, research and reflective practice.
- Uses reflection to analyse and clarify direction for ongoing nursing practice.
- Responds to challenging situations and learns from nursing practice through reflection in decision making and problem solving (Nursing Council of New Zealand, 1996c:16).

The use of reflective learning in nursing education programmes is associated with a shift in focus from the nurse who was proficient in the execution of technical tasks, where there was a clear emphasis on what the nurse should do, to the nurse as a critical and reflective thinker. It has been noted that Donald Schon (1983, 1987) developed the concepts of “reflection-in-action” and “reflection-on-action” (Schon, 1987:28) to describe processes of critical thinking which he relates to the issue of knowledge and knowledge development. For Schon, reflection-on-action refers to thinking back and reflecting on how knowledge-in-action contributed towards an unexpected outcome in nursing practice. He considers that knowing-in-action is how knowledge is developed in a practice discipline, and that the knowing is in the action (Schon, 1987). Reflection and reflexivity can be seen as a way of resisting the positivist view, dominant in the production of knowledge through empirical enquiry, and can be considered to have a legitimating role in other ways of knowing, such as the tacit knowledge proposed by Polanyi (1967) or the personal knowledge in the patterns of knowing proposed by Carper (1978). Reflection-in-action is also evident in the work of Patricia Benner (1984) in relation to expert practitioners, where she identifies that it is a process that is done without the practitioner being able to articulate what it is that has been done. Reflective practice therefore can be seen to have two functions - the development of knowledge and the construction of an identity. As Charles Taylor (1989:178) puts it: “... reflexivity consists of exploring what we are in order to re-establish this identity”.

Foucault relates practices of the self to the constitution of the self as an autonomous subject, and in terms of truth. As he said: “ ... I wish to know how the reflexivity of the subject and the discourse of truth are linked ...” (Foucault, 1982:207). Within the process of reflexivity or critical self awareness, the potential emerges for exploring new forms of experience. He makes this clear in the preface to *The History of Sexuality, Volume II*, where he states: “There is no experience which is not a way of thinking, and which cannot be analyzed from the point of view of the history of thought” (Foucault, 1984:335). It would appear that there is little difference between what Foucault calls ‘reflexivity’ and the notion of ‘reflection’. Practices of the self for Foucault are concerned with reflexivity, as outlined above, where the emphasis seems to be on an individual’s thought processes to make sense of an experience or think about something in a different way. As he claims

There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all (Foucault, 1985:8).

Reflection in nursing, however, has emerged in association with a focus on the emancipatory potential of critical theory, and it is helpful to examine how this relates to Foucault’s notion of reflexivity.

Reflection in nursing education and practice

Carolyn Emden (1991) notes that reflection has arisen from the critical social theory paradigm. She asserts that it has strategic use in nursing for empowerment and emancipation in improving nursing practice and generating nursing knowledge. It is a way of challenging preconceived ideas and the basis for them. For Annette Street (1991:1), reflection “... provides the basis for an examination of nursing actions in order to identify ways in which actions are embedded, informed and

transformed by different forms of knowledge". She clarifies how, for nurses, reflection has an empowering role, in that it enables nurses

to become fully cognisant of their own knowledge and actions, the personal and professional histories which have shaped them, the symbols and images inherent in the language they use, the myths and the metaphors which sustain them in their practice, their nursing experiences, and the potentialities and constraints of their work setting

According to Boud et al (1985), reflection constitutes intellectual and affective activities individuals utilise in order to explore their experiences. This is said to lead to new appreciations and understandings. It is made clear, however, that reflection is of little use unless accompanied by some sort of action (Kemmis, 1985). This is illustrated in the two different aspects of reflection identified by Schon (1987). Reflection-in-action is considered to be a process of identification of a novel situation or new problem that the learner or practitioner may encounter and thinks about while acting (Schon, 1987; Boud and Walker, 1991). Essentially this type of reflection is concerned with solving problems during practice. But it also can be a way in which new theoretical perspectives develop (Reed and Proctor, 1993). On the other hand, reflection-on-action is a retrospective activity which is undertaken to reveal the knowledge used during a particular action (Palmer et al, 1994:67).

The notion of reflection seems to be used in several ways in the nursing literature, however, there is clearly an agreement that reflection and/or reflexivity is associated with self awareness which does two things. First, it has the potential to lead to changes in a nurse's practice, and second, it is an activity which a practitioner uses to identify what may or may not have been done in a particular nurse-patient interaction. Either way, as Lauterbach and Becker (1996) claim, it is through the experience of reflecting on oneself that self-awareness occurs and understanding of the experiences of others is enhanced. In another sense, reflexivity is a form of examination, that is, self-examination. Self examination equates with self

knowledge, and knowing oneself in order to care for the 'sick' means that the nurse must care for the self as an essential component of caring for others (Lauterbach and Becker, 1996).

Since reflective practice involves the modification and selection of theories which do not immediately fit with particular practice issues, in this way theories may be used in new ways as well as theories being developed from both experience and practice (Reed and Proctor, 1993). This freedom to develop new knowledge represents in Foucauldian terms, "practices of freedom" (Foucault, 1985). However, Reed and Proctor (1993:27) suggest, there is a contrary view in relation to such freedom - it may make the practitioner a 'dangerous' individual. If the knowledge of individual practitioners is not able to be codified or communicated, they may take risks or not adhere to procedures; "... behaviour which makes them difficult to control or supervise, and which may make it difficult to ensure the legal safety of nurses and the physical and psychological safety of patients". Given the emphasis on autonomy, accountability and independent clinical judgements and decision making seen to be important for nurses and nursing, this is an astonishing assertion. Even more noteworthy in this respect is the suggestion these writers make of the perceived necessity for nurses to have their practice closely monitored to ensure patient safety. This suggests that nurses are somehow unable take responsibility for their own standards of safe and competent practice. The Nursing Council's definition of reflective practice makes it clear that reflection is an activity expected of nurses, when in its definition it asserts

By engaging in a "reflective conversation about practice situations" nurses and midwives are able to surface the knowledge embedded in their practice to provide new meanings and insights. In this way nurses and midwives develop knowledge about their practice that challenges conventionally accepted rules and procedures (Nursing Council of New Zealand, 1996c:24).

The 'dangerousness', of reflective practice, it can be argued might relate more to the self surveillance that subjects and disciplines the nurse within a network of power relationships as a technology of the self. This can be explored through Foucault's insights into the notion of confession.

True confessions - the effect of self-surveillance

Foucault (1985) points out that subjectification which involves the monitoring, testing and improving the self is the only way of living as an ethical subject. Subjectivity is maintained through individual self-surveillance and self-correction to what is defined as norms. Foucault's (1980:155) description of surveillance is that it is "(a)n inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself". In this sense, the subjectivity of the nurse is being created through the surveillance of confessional practices which are part of reflective practice. Such practices have been identified as occurring in psychoanalysis Flax (1990), in which an 'expert' is consulted in determining the 'problems' of an individual. In the process of reflection in learning there is a similar requirement to consult an expert. Students, in learning to be reflexive, are required to give accounts - either written or verbal - of situations or incidents from their clinical experience and reflect on these to identify what might have been done differently. In doing this, the teacher or lecturer becomes privileged as an expert to whom the learner, in a sense, confesses. But more importantly, perhaps, there are inherent risks in the practice of reflection in the learning process in terms of identifying unethical or even incompetent practice. As Rich and Parker (1995) caution, disclosure of such information can place the teacher in an invidious position in that an ethical dilemma is created for both student and teacher in terms of what should be done in the event that there is a revelation about unsafe practice.

Thus in assessment of a student's ability to be reflexive, the idea of technologies of the self as a technology of power can be illustrated through Foucault's use of the concept of confession, which he describes as

a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile; a ritual in which the truth is corroborated by the obstacles and resistances it has had to surmount in order to be formulated; and finally, a ritual in which the expression alone, independently of its external consequences, produces intrinsic modifications in the person who articulates it: it exonerates, redeems and purifies him, it unburdens him of his wrongs, liberates him, and promises him salvation (Foucault 1978:61-62).

There can be no doubt that the pervasive nature of the confession is apparent in education. It has, as Foucault (1978:59-60) reminds us "... spread its effects far and wide. It plays a part in justice, medicine, education ... one confesses in public and in private, to one's parents, one's educators, one's doctor ... The obligation to confess is now relayed through so many different points ...". In reflective activity there is a corresponding production of a discourse of truth of an activity in the sense that in its reconstruction the activity is thought of as it was but also as how it might have been. In terms of the way Foucault uses the notion of confession, it can be seen that in a learning situation a student is obliged to confess in order to learn. This is not to suggest that this is bad, more that, in Foucault's terms, it is "dangerous".

The discourse of reflection and its associated practices in nursing is embedded within the idea of the confession. It may have a liberating effect in terms of its potential for empowerment, but equally, it represents a different pattern of control. Hence it is a new form of subjection or discipline. As Patti Lather (1991) cautions, empowerment may become unproductive and perpetuate relations of dominance.

Caring and nursing

A further concept emphasised in nursing education and nursing practice is caring, which also acts to position the nurse in a particular subjectivity. It is helpful to provide an overview of concept of caring as it is used in nursing in order to see its relationship to nursing.

Caring¹ has always been linked with nursing. Inherent in Florence Nightingale's views of nursing was a clear duty of the nurse to care for the sick and the diseased (Vicinus, 1985). Ashley (1976) wrote extensively about the historical caring role of the nurse and asserts that nurses were "ordered to care". The notion of caring has continued to be seen as an integral part of nursing. In New Zealand the New Zealand Nurses Association (1984:3) immortalised caring within its definition of nursing as " ... a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situations". In this definition nursing and caring are inextricably linked with each other. Leininger (1984:1) makes this relationship apparent when she asserts "caring is nursing and nursing is caring".

Colliere (1986) notes that social and economic forces have influenced nursing to move away from its earlier relationship with caring which resulted in the notion of caring being replaced by an emphasis in the ability of the nurse to be expert in the undertaking of technical tasks and procedures. This, she claims, has produced a tension between performance of the tasks of nursing and the ability of the nurse to care for others. Colliere demonstrates this point when she says caring is not identified as a specific legitimate and personal activity, but defined in terms of the

¹ Caring has been conceptualised in different ways in terms of its association with nursing practice. Morse et al (1991) identify five conceptualisations of caring from the nursing literature: as a human trait, as a moral imperative; as an interpersonal interaction and as a therapeutic intervention.

nurse's role and in terms of specific behaviour attributed to that role. Phillips (1993) notes that there has been a resurgence of the notion of caring, and asserts that it has become a focus for nursing in the 1990s. She identifies that in the nursing literature, the word care appears as often as the word nurse.

Various nurse scholars have used the notion of caring to relate it to the essence of nursing, such as Benner and Wrubel (1989) who claim that it is central to reflective nursing practice. Others have emphasised caring in nursing as an 'ethic'. Much of this has been influenced by the work of Carol Gilligan (1984), whose feminist approach to ethics has become widely adopted in nursing. Some of these views of caring are outlined to illustrate the way in which the discourse of caring has become influential in nursing scholarship.² For some, caring has been called "the ethic of caring" (Fry, 1988), the "caring ethic" (MacPherson, 1989), and "virtue ethics" (Brody, 1988). In this respect, then, caring is postulated as a virtue to which a nurse should aspire.

The notion of caring in nursing was operationalised in the work of Peplau (1952) where caring was postulated as the therapeutic use of self. Fundamental to the notion of care within the context of an ethic of caring, is what Noddings (1984) refers to as the recognition of ethical selves. The "ethical self" is seen in terms of a relationship between an actual self and a vision of an ideal self as one who is a caring person. In Noddings' view, the ethical self emerges from the recognition of relatedness, and within this relatedness is a motivation to care for others in the sense of "I must". The similarity between Nodding's "ethical self" and what Foucault refers to as the "ethical substance" as one of the elements to be considered in the relationship of the self to itself is clearly apparent here. Mayeroff (1972)

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No attempt is made to provide an exhaustive review or analysis of the literature on caring. For such a review, refer to Morse et al (1991) and Kyle (1995).

suggests caring is a relationship that is part of the self, yet separate from the self, and has described a set of characteristics that epitomise any caring relationship. However, as Brody (1988) points out the ethics of caring is not simply a matter of actions that ought to be done, but rather that caring implies that the carer has developed characteristics or character traits which could be called virtues. These virtues include attributes such as patience and compassion.

The virtue aspect of caring is problematic because it is difficult to determine what it is that the nurse may possess that any other caring person does not have. The differences between 'lay caring' and 'professional caring' have been explored by Kitson (1987) who concludes that there is a need for nursing to be clear about the dimensions of caring. An additional dimension to the caring aspects of nurses which differentiates between the 'lay caring' and 'professional caring' is suggested to be the intimate relationship that a nurse has in terms of the body of the patient. Campbell (1984) notes that this is apparent in the expectation that a nurse touches or handles the patient's body in a way that leaves a sense of privacy intact. More recently Jocelyn Lawler (1991) has investigated the work of the nurse in relation to the body which illustrates how this happens. This illustrates the complexity of the practice of caring in terms of the notion of trust, or demonstrates as Benner and Wrubel (1989:1) put it "... caring practice requires connection and concern for the person".

Anne Griffin (1983) considers caring to be a mode of being or a natural state of human existence in which human beings relate to other human beings and the world. She sees it as a central value in the nurse patient relationship. Nel Noddings (1984) view of caring is that it is a natural sentiment of being human. Similarly, Sally Gadow (1985) asserts caring is the foundation for nursing, and argues that this is because nursing is linked to protecting and enhancing human dignity of

patients receiving health care. In her analysis of caring she explores and operationalises the notions of truth - telling and touch in nursing actions that are part of the nurse-patient relationship.

Two nurse scholars who have incorporated caring into frameworks for nursing, and have been influential in nursing education and nursing practice are Watson (1985) and Leininger (1984). Watson (1985:13) built on the views of Gadamer to propose caring as the foundation of “nursing as a human science”. She views nursing as a moral ideal, as a way of preserving humanity within society, and as a human value in which there is “... a will and a commitment to care, knowledge, caring actions, and consequences” (Watson, 1985:29). For Leininger (1984) caring

refers to the direct (or indirect) nurturing and skillful activities, processes and decisions related to assisting people in such a manner that reflects behavioural attitudes which are empathetic, supportive and compassionate, protective, succorant, educational and others, dependent upon the needs, problems, values or goals of the individuals or group being assisted.

These views about caring are seen to be significant for nursing in the sense that they describe what it is that nurses do in terms of the somewhat mysterious notion of ‘nursing care’. The importance of this for the nursing identity is clearly that it is not only that nurses have technical skills which are able to be demonstrated through the efficient carrying out of particular tasks in relation to the requirements of their care, but that there also something else that happens in interactions between nurses and ‘patients’. Thus descriptions of caring identify that there is an ethos which underpins nursing activity. What is consistently articulated in the discourse of caring is an emphasis on the relationship between patient and nurse. There is an emphasis on the art - or artistry of nursing which increasingly defines nurses as “knowledge workers” (Antrobus, 1997).

There has, however, been criticism of the notion of caring in nursing. Dunlop (1986) warns that operationalising caring as a finite set of behaviours risks the creation of something different from what it is that nurses presently understand. Some have cautioned against the emphasis of caring because of its gendered association with women (Fisher and Tronto, 1990). On the other hand Patricia Gray (1992) has specifically criticised the lack of gender emphasis on Watson's theory of caring, which, she claims, "implies that gender is unrelated to caring or irrelevant to the concept of caring" (Gray, 1992:89). Further, she challenges assumptions underlying caring theories, in particular, masculine spiritual elements, in Watson's theory of caring. Gray's critique identifies the need for nurses to be critical rather than passively accept the imposition of prescriptive views about defining caring in relation to nursing. The uncritical acceptance of theories of nursing also illustrates how nurses govern themselves through the production of a caring self, or aspiring to be a caring nurse according to prescriptive views.

Street (1992) equates the insistence of being seen to be a caring nurse with what she describes as a "tyranny of niceness". She asserts that since nurses aspire to be "caring" and "nice", the relevance of caring in nursing is negated. It also has connotations of Reverby's (1987) "ordered to care". Kim Walker (1994) is of a similar view, when he contends that caring represents a regime of practices, within which the nurse's sense of herself may be effaced or even erased. Walker suggests that a tension exists between being "caring" and being "nice", and this initiates a tyranny. Here the nurse's sense of self is

conflicted between her need to be liked and to live up to the image she (and others) have of her ... at the same moment she is denied a form of agency in which she can 'speak of herself' without fear of being silenced or diminished in any way (Walker, 1994:12).

In that the literature reinforces how a 'caring' nurse should both feel and behave in both a descriptive and prescriptive way, the discourse of caring is a technology of power, in particular, a technology of the self. It is important to reiterate Foucault's assertion that it is not that this is bad, rather that it is dangerous. Humanism, within which the discourse of caring is philosophically positioned, incorporates ideas of a core of human nature or an essential 'self'. The humanist assumptions, on which caring is predicated, reinforce a singular regime of truth (caring) for nursing, and suggests a stable and secure identity for the nurse (a caring nurse). Therein lies the dangerousness.

The discourse of cultural safety

In chapter nine, the way in which cultural safety was introduced into nursing education³ in New Zealand was explored. There, this notion was examined in relation to the tenets of a critical social theory, and in particular, in terms of critical pedagogy. The introduction of cultural safety into nursing education represented an undertaking by the Nursing Council of New Zealand to ensure that nurses developed self awareness and non-judgemental attitudes. The emphasis of cultural safety, is concerned with notions of empowerment and emancipation in relation to those individuals and groups who are different from the culture of the nurse.

Initially, as identified in chapter nine, the requirement for cultural safety existed within the Nursing Council of New Zealand's standards for registration of comprehensive nurses as one of the outcomes of each nursing course. With the publication of its *Code of Conduct for Nurses and Midwives* in 1995, which the

³ Cultural safety is also a requirement for midwifery education. It can be noted that the controversy surrounding its introduction was seen to be centred only on comprehensive nursing education courses, and not on midwifery education programmes which also take place in polytechnics. The requirements are identical. That there was no concern expressed about cultural safety in midwifery education programmes, may however, be because there is no differentiation made by some between the two different professions of nursing and midwifery.

Nursing Council of New Zealand forwarded to the 45,000 or so nurses and midwives who renewed their annual practising certificates in 1995, this changed. In this document, there is a clear requirement for cultural safety to be an integral part of nursing practice. Principle three, “the nurse or midwife respects the rights of patients/clients”, has as one of its criteria that the nurse “practices in a manner which is culturally safe” (Nursing Council of New Zealand, 1995:5). In addition, the New Zealand Nurses Organisation *Code of Ethics*, published in 1995, states that cultural safety is integral to nursing practice. Thus there is a stated expectation from nursing that nurses are required to be culturally safe in their nursing practice.

Cultural safety can be considered, therefore, as a technology of the self which shapes the nursing identity. It represents a particular ideal, or subject position to which the nurse aspires in order to be seen as a ‘good nurse’. Like reflective practice, and caring, cultural safety in nursing practice represents an attitude, which for Foucault (1984:39) is

a mode of relating to contemporary reality; a voluntary choice made by certain people; in the end a way of thinking and feeling; a way, too, of acting and behaving that at the one and the same time marks a relation of belonging and marks itself as a task.

It can be argued, however, that the notion of voluntary choice to which Foucault refers is problematic, given that failure to demonstrate culturally safe practice has the potential for the nurse to be disciplined through the provisions of the Nurses Act. However, the expectation that the nurse incorporates cultural safety into her practice suggests that this will be done voluntarily as part of the ethos of nursing. Thus nursing identity is shaped through practices of the self, and in this way is governed by more than technologies of domination. She implicates herself in her own discursive constitution.

In summary, the discourses of cultural safety, reflective practice and caring all represent the way in which power relations exist as technologies of the self which shape the nursing identity, and produce certain forms of subjectivity. The discursive practices of these discourses position the nurse within a particular space that may ultimately be considered as no different from the dominant discourses nurses seek to resist. Such technologies of the self represent what Foucault (1977) refers to as “modern disciplinary society in which various mechanisms exist that require self policing. But they are also in a sense, “practices of freedom” identified by Foucault (1982) as significant in terms of resistance. The next (and final) chapter explores how power is exercised in relation to this notion.

CHAPTER TWELVE

(RE)POSITIONING THE NURSING IDENTITY

Maybe the target nowadays is not to discover what we are, but to refuse who we are. We have to imagine and to build up what we could be ... We have to promote new kinds of subjectivity ... Foucault, 1982:216).

The overarching argument of this thesis has been that the nurse is discursively positioned within various discourses which shape and construct the subjectivity of the nurse as a particular identity. Clearly, issues of knowledge and power in relation to processes of education are crucial elements of this. In that this construction of an identity, referred to as the nurse takes place within a network of power relations, and that these exist as social and political forces, this thesis has endeavoured to make these forces visible. However, the concern of this thesis has been with the question of how these forces construct and position. The analytic grid by which to do this has been Foucault's power/knowledge problematic, thus from a methodological perspective, the intent has been to examine how power operates to construct the nursing identity, through an analysis of the tenets of power and knowledge that constitute the power relations in which the nursing identity is enmeshed.

Although the work of critical theorists such as Habermas, Freire and Fay has been utilised in this thesis to illustrate the emergence and influence of critical social theory and its emancipatory intent, the work of Foucault has been heavily drawn upon to describe and analyse the construction of the nursing identity from a perspective which provides a different way of viewing the interrelationship between power and knowledge in nursing education in New Zealand. As James Marshall (1990:22-23) explains, the work of Foucault offers

a new framework - not for studying the past, but for assessing the present. The general framework is constituted by an analytic grid of power-knowledge, the method of genealogy, and new notions of time, especially of rupture and discontinuity.

Thus Foucault provides a perspective by which to explain a critical ontology of the nursing identity, which in essence, represents a history of the present. However, this is only one view of the history of the present. It needs to be remembered that in the Foucauldian sense of an ontology of the present “(t)here is a multiplicity of presents, a multiplicity of ways of experiencing those presents, and a multiplicity of the “we” who are subjects of that experience” (Dean, 1996:210).

This chapter draws together the components of this thesis to provide an overview of political and social forces which produce and reproduce the nursing identity, and operate to position the nurse within particular discourses and spaces in the health environment. In addition, it explores the idea of possibilities for resistance in terms of counter discourses to the dominant discourses of the nursing identity.

Technologies of domination

Important in this thesis has been the assertion that the nursing identity is positioned within dominant discourses, and it is helpful to review what is meant by this claim. According to McLaren (1989:181), “... we can consider *dominant* discourses (those produced by the dominant culture) as ‘regimes of truth’, as general economies of power/knowledge, or as multiple forms of constraint”. (Italics in original). These features are recognisable in the construction of the nursing identity, and the task of this thesis throughout its various chapters has been to analyse how this is so.

In asserting the discursive construction of the nursing identity within systems of power relations, and within dominant discourses, it is helpful to recapitulate on the dimensions of this analysis. It is apparent that this is underpinned by Foucault's views of power as well as the interrelationship between power and knowledge, and his notion of discourses, or "... practices that systematically form the objects about which they speak" (Foucault, 1972:49). This began with an analysis of the construction of the nurse as a docile body, positioned within the discourses of medicine and gender. Initially the nursing identity became located in a space created by the need to have an individual with the skills to care for the sick and diseased. In this respect, the vision of Florence Nightingale was clearly influential in developing a particular woman who, during and after a period of training in a hospital could fill this space without threatening the function of medical practitioners. This vision of such an identity was transported to various parts of the world, and the requirements to become a nurse, became enshrined in statute, creating the nurse as a legal subject.

For the best part of a century in New Zealand, nurses were discursively positioned within a hierarchical structure, where every nurse knew her place. This can be seen to have had a far reaching effect on the nursing identity in relation to nursing education and nursing practice. The hierarchy existed to facilitate the provision of nursing care, as such care was organised in relation to a system in which various tasks were carried out according to the particular 'level' of the nurses. Most of the 'hands on' nursing care was provided by a student workforce. This meant that there was always a need to have a more senior nurse in a supervisory role. A structured system in which to work, with an immediate supervisor was the environment in which nurses both learned to be nurses and worked as nurses from the time that formalised nursing education commenced in New Zealand. Within the location of the hospital, the disciplinary processes of training produced a particular identity

who undertook specific actions and had specific skills. This production of the 'docile body' of the nurse worked through constructing the space as well as organising the timing within which the nurse functioned. As Foucault (1977:143) points out, the aim of this disciplinary space was to

establish presences and absences, to know where and how to locate individuals, to set up useful communications, to interrupt others, to be able at each moment to supervise the conduct of each individual, to assess it, to judge it, to calculate its qualities or its merits.

The techniques of surveillance implicit in this disciplinary process operated through a network of hierarchised and continuous surveillance; essentially anonymous in character, but everywhere. It was built into the structure of the hospital, manifested in the creation of rituals and routines. It constituted the nursing identity as an object able to be described and analysed, and did so in order that the nurse was in a position of visibility where she was able to be maintained in that place under a normalising gaze (Foucault, 1977). This normalising judgement, Foucault (1977:184) says produced

a whole range of degrees of normality indicating membership of a homogenous social body but also playing a part in classification, hierachization and the distribution of rank. In a sense the power of normalization imposes homogeneity, but it individualizes by making it possible to measure gaps, to determine levels, to fix specialties and to render the differences useful by fitting them to one another.

Rupture and discontinuity

The shift from this position through the relocation of nursing education disrupted the dominant view of the nurse in two clearly identifiable ways. First, nursing education was moved from the normalising gaze of the hospital based apprentice-like system, in which the skills of nursing were learned 'on the job', and in which

the knowledge nurses were seen to need was considered as an adjunct to medicine. This was evident in the entrenchment of nursing within the assumptions and values of the biomedical model. Second, within this different educational environment, nurse educators endeavoured to produce a different nursing identity through an emphasis on the developing array of nursing models and theories, and utilisation of the nursing process to structure student learning.

That there was an expressed need to educate a different nursing identity is explicated by Tanner (1990:295), who asserts

We continue to struggle with our content-oriented curricula that attempts simultaneously to 'prepare' nurses to practice in a biomedically oriented disease care system and to educate nurses to be responsible health-care professionals committed to the social changes necessary for health promotion and disease prevention. And we continue with an institutionalized commitment to a rational-technical model of education that may no longer serve us well for educating caring and critically thinking nurses.

The structuring of nursing education within the assumptions of the biomedical model existed for almost seventy years in New Zealand. The heavily prescribed curriculum requirements emphasised and reinforced the source of knowledge for nurses and nursing as derived from the disease orientation of medicine, associated with cause and effect, treatment and cure. Knowledge for nurses which was structured around body systems and medical specialties was also 'taught' to nurses by medical practitioners, and the sources of information by which to memorise facts in terms of the notion of received knowledge identified by Belenky et al (1986) were frequently texts authored by medical practitioners. Student nurses were not necessarily employed to learn, but rather to constitute the workforce. Disrupting this tradition resulted in disapproval and discontent among those responsible for staffing hospitals, as well as claims that nurses would become overeducated.

Attempts by nursing to shift from within this model are inextricably linked with views about, and value accorded to, particular types of knowledge. The belief that the skills nurses need to have are associated with implementing the orders of the medical regime, is perpetuated in part by the historical and discursive notion of the nurse as a woman who is not an autonomous practitioner but is always positioned in relation to the medical practitioner. A further part of perpetuating this belief comes about from the pervasive ethos that nursing is about doing and the best place for nurses to learn about 'doing' nursing is in a hospital, caring for the sick. As this thesis has illustrated, the truth claims of this dominant discourse persist.

Exploration and analysis of knowledge illustrates its relationship with power. It highlights that certain knowledges are privileged, as some types of knowledge are accorded more value. A crucial part of the analysis in this thesis has been to analyse how this happens, and in this regard the insights of Foucault are apparent. Just as Foucault does not accept the notion of sovereign power, nor does he accept the sovereignty of knowledge. By this is meant that he rejects the notion of epistemic sovereignty which constitutes knowledge as a unified system of truths, legitimated through rational means which stand above other statements which are not acquired through conformity to this method of rationality. Foucault asserts that no scientific discourse represents all truth, and demonstrates his aim to "break free" from this theoretical privileging of sovereignty in his analysis of power (Foucault, 1980). He claims that through his conception of what he called "genealogical analysis" it is possible to emancipate historical knowledges from subjection, and to "render them capable of opposition and of struggle against the coercion of a theoretical, unitary, formal and scientific discourse. It is based on a reactivation of local knowledges - of minor knowledges; as Foucault (1980:85) explains "... in opposition to the scientific hierarchisation of knowledges and the effects intrinsic to their power". Foucault (1980) makes it clear that in critical analysis both his earlier archaeological

analysis and later, his genealogical analysis, have a place in identifying subjugated knowledges. He claims that if it were to be characterised in two terms, then

‘archaeology’ would be the appropriate methodology of this analysis of local discursivities, and ‘genealogy’ would be the tactics whereby, on the basis of the descriptions of these local discursivities, the subjugated knowledges which were thus released would be brought into play (Foucault, 1980:85).

The continuing struggle for nursing to develop and utilise knowledge it sees as beneficial to its socially mandated role in health care, and to address the subjugated knowledges of nursing, is evident in the establishment of undergraduate nursing degrees. The nurse of the future was to be educated not only to be a competent performer of particular skills, but as a critical and reflective thinker. In this way the subjugated knowledges of nursing, embedded in the practice of nursing, could become recognised and valued. An emphasis on different approaches to facilitating student learning, through critical self-awareness held promise for achieving this. Hence the work of critical social theorists introduced in examining recent curriculum changes in relation to different knowledge included in nursing education highlights how new forms of knowledge construct the nursing identity.

The introduction of the notion of cultural safety into nursing education, with its emancipatory agenda was one way of transforming thinking through the use of new types of knowledge. The unintended consequences of cultural safety, however, identify sociopolitical forces which intersect with nursing education to subjugate knowledge which does not fit within the dominant discourse. Thus the debate centred around cultural safety illustrates that despite what the nursing profession may think, and indeed articulate about nursing education, the perception that nursing is about having practical skills and is associated with a particular type of knowledge, remains a dominant view.

The politics of truth

Nursing education exists to prepare nurses to provide a particular service to society within the health care system. Instability and change existing in the health service environment in New Zealand, however, particularly within the last decade, continues to have an impact on what is seen to be needed within nursing education. This can be seen in the views of employers of nurses, who seem to want a different product from that which nursing education programmes actually produce. One of the significant tensions that remains however, is whether or not the graduates are able to meet the needs of clients of the health services - the consumer. Thus there is an important underlying issue that remains essentially unanswered - that is, how is it determined how a nurse functions on registration. Despite comment about the ability of nurses prepared in the education system for registration, this appears to be based on anecdote, and does not seem to incorporate in any sense the view of the consumer. There is no current research which substantiates claims of inadequacy - either from the perspective of the consumer or from the perspective of employers.

The issue of whether or not nurses are being adequately prepared to meet the needs of employees is not one which is solely confined to New Zealand (Leddy and Pepper, 1993; Happell, 1996; Clare, 1997). Leddy and Pepper (1993) suggest that the adequacy of nursing education in preparing nurses for practice has been debated for many years. The essence of the argument, they point out, seems to be concerned with the level of competence expected on the commencement of employment in the health service. Nursing education programmes do not attempt to produce expert practitioners, but rather beginning practitioners, and the differences in this respect have been illustrated by the work of Patricia Benner (1984). This situation is not unique to nursing but is also the case for occupations such as teaching and the law, where a practitioner is not expected to be an expert on entering the workforce. Instead, in these occupations, there is recognition that there

are beginning practitioners who need the guidance and mentorship of a more experienced practitioner. It could be argued that one of the prevailing reasons why nursing is considered differently in this regard is because of a view that nursing is about 'doing' and this is valued more in nurses than any cognitive ability.

It seems apparent from the contemporary literature about the stated aims of nursing education, both in relation to the requirements for registration, as well as for an undergraduate degree, that there are at least three identifiable components to the nursing identity. These can be considered as the skills of nursing, the knowledge which comes from what may be called scholarly inquiry, and the framework for nursing practice by which the individual nurse makes sense of her self and her relationship with nursing. It is also apparent nursing programmes have placed an emphasis on the acquisition of skills - or as Habermas (1971) has asserted, the 'technical' interest. The focus on the technical expertise of nurses is what appears to be accorded the most value, and this perpetuates the belief that it is what the nurse does that is of primary importance which reinforces the dominant view that the nurse *does*. This creates tensions between those who view the nursing identity in terms of specific skills and competencies, and those with a vision of a nursing identity able to think critically and be reflective, and highlights that there is more than one truth about the way that nurses should be prepared for registration. This is summed up succinctly by Annette Street (1995). She points out that the traditional view of the nurse can be seen to be primarily a female, who during a process of training to be a nurse within a hospital is

inaugurated into the mysteries of sponges, bedmaking and cleaning, activities which she must unlearn and relearn in the prescribed manner. She is also initiated into the mysteries of science, carefully organised into lectures which reflect the medical curriculum, so that she learns about the body as a number of systems which can become dysfunctional and then cured by the use of drugs or technology overseen by the ominescent doctor. Under careful supervision she is trained in all the requisite attitudes, rituals and routines which shape and dominate the regime of the sick (Street, 1995:3).

This view of preparing the nurse is one which was at the essence of nursing education in New Zealand, until both the location and beliefs about preparing the nurse in an educational environment represented a shift in thinking to the present situation. Now it is believed, by nurse educators at least, that the nurse of the 1990s should be able to

demonstrate a strong commitment to and respect for their nursing colleagues and an ability to engage in assertive advocacy to ensure the best interest of the patient. They work co-operatively with medical and paramedical staff, sure of their own unique contribution to the health care team. They engage in reflective documentation of their nursing actions and intentions, regularly journalling their own practice in order to value, analyse and change it appropriately. They are independent thinkers who act responsibly and develop effective strategies of accountability (Street, 1995:3).

Such a vision, it must be noted, is rarely articulated outside the nursing education system.

The nursing identity: trained or educated?

Discourses of education and training are frequently seen as distinctly different, and are defined here to illustrate how particular views can be held which are based on an assumption of fundamental difference. Training, on the one hand, is seen to be associated with the development of practical skills that are needed for a particular workplace, as well as knowing how to perform those skills in a competent way. In the case of nursing, this workplace is seen to be the hospital, which is hardly surprising, given that the majority of nurses are employed in hospitals. Education, on the other hand, is seen to be concerned with the formation of concepts the development of ideas and cognitive ability, and requires both a knowledge base as well as understanding. In addition, education is said to need some sort of theoretical framework, which leads to understanding and action (Bedford et al, 1993).

Such distinctions between education and training, however, makes them artificially absolute. It must be recognised that each of these discourses intersects with the other. If they are seen as dichotomous, there is a risk of separating the activities of education from the area of practice, since it is training that is seen to be more concerned with the achievement of outcomes without any need for a theoretical base. Education, however, is concerned with both processes and outcomes. Perhaps if they were considered as complementary, then it may expose the hidden curriculum Pitts (1983) identifies as existing in nursing education, as nurse educators continue to focus on what graduates will need to be able to do on entering the workforce. Whether it could dispel some of the views about the deficiencies of graduates from comprehensive nursing courses which seem to be predicated on an assumption that because what the students undertake is an educational course then they lack practical experience and as a consequence, clinical skills, is a debatable matter.

Use of Foucault's insights to analyse knowledge and power in the construction of the nursing identity within the discourses of education and training identifies how nurses themselves engage in particular regimes of conduct which produce particular regimes of truth. Judith Clare (1991) suggests that nurses maintain and perpetuate the conditions of their own domination through the processes of cultural reproduction. This is most apparent in relation to the relocation of nursing education into the tertiary education sector from the hospital based system of training nurses for employment in hospitals. While there was one discourse in relation the ability of the nurse to learn to 'do' there was in effect a counter discourse which wished to emphasise the ability of the nurse to 'think'. Hence the competing discourses of training and education can be identified as underlying how the nursing identity is shaped. These both contribute to competing claims about how a nurse should be prepared for registration as well as what a nurse should be able to do upon entering

the workforce as a registered nurse. These claims come from nurses working in clinical environments, nurse educators and employers of nurses. These tensions which existed at the time of the commencement of the first comprehensive nursing courses have not disappeared. If anything, in the 'reformed' health system of the 1990s they remain a cause of tension in relation to the education of the nurse.

Health 'reforms' and the nursing identity

The somewhat chaotic nature of the health care system (in that it is constantly in a state of change), which operates on a commercial model in New Zealand at present has an emphasis on a nursing identity who does rather than thinks. The positioning of the nursing identity within the health system is also influenced through the notions of professionalism and industrialism. By industrialism is meant the conditions of work of nurses in the health service, salary scales and career pathways for nurses. Short and Sharman (1995) relate this to trade union activity, and highlight the different approaches used to argue for the positioning of nurses in the health care system. It may be that the discourse of industrialism can not provide the perspective needed to for nurses to position themselves in the spaces opened up by reforms within the health system, which have been a particular feature over the period of time that undergraduate degree programmes have been introduced into nursing education in New Zealand. If professionalism is about the development of nursing as a discipline and having knowledge(s) for use in nursing practice, then it needs to be considered that this may be more useful than any industrial debate to reposition the nursing identity for the future. These may not be necessarily mutually exclusive arguments; interrelated as they are. Perhaps what needs to become a focus is the strength of knowledge of nurses in relation to patient outcomes. Whether this can be achieved while there is insistence that enrolled nurses need to be available to provide nursing care and are legally entitled to claim the title 'nurse' (O'Connor, 1995) is a current tension in nursing in New Zealand.

There can be little doubt that the existence of different categories of nurses perpetuates the hierarchical positioning of nursing as well as negating the view that the practice of a nurse is possible only because of a particular knowledge base. The debate about the retention of enrolled nurses in the health care workforce seems more focused on a concern that unregulated health workers will be introduced to replace enrolled nurses than on identifying what it is in terms of nursing knowledge that enrolled nurses may or may not have. Given that the theoretical component of the programme for this group consists of little more than eight weeks in a one year training programme, perhaps this is good reason not to argue that they are really any different from other health care workers. The emphasis of the argument is also focussed on a lack of accountability, however, the Health and Disability Commissioner's Code of Rights for Consumers (1996) would suggest otherwise.

The structures and systems seen by nurses to be important, and within which particular systems or models of nursing care delivery systems developed perpetuate power relations which act to reinforce dominant discourses about nursing and nurses. The market-driven health care system of the National government in New Zealand within publicly funded hospitals resulted in management structures which in many instances excluded nurses from being in what some consider positions of power and influence, and far removed from decision making. With the introduction of new management structures the long held tradition of a hierarchal nursing structure disappeared. Nurses have lamented this loss and claimed that there have been deleterious effects on nursing practice and patient safety has been compromised, and have complained that this amounts to deskilling (Wilson, 1995). The influence of changes through disestablishing particular positions is taken up by Michael Apple (1982), who has analysed how deskilling occurs through the establishment of specific management roles. He points out that

workers are continually deskilled (and of course some are “reskilled”). The skills they once had - skills of planning, of understanding and action on a whole phase of production - are ultimately taken from them and housed elsewhere in a planning department controlled by a manager.

This deskilling activity can be seen in the disestablishment of many nursing positions in hospitals which had an overview of a hospital or a particular service that came within the responsibility of a hospital, for example, a district or community nursing service (Williams, 1996).

Philip Strong and Jane Robinson (1988) in commenting about change in the health system in England (a model later adopted in New Zealand), to a system of general management which replaced the triumvirate management system, identify that this was a feature of the administration of hospitals for some one hundred years. In the National Health System in England they note that within the health service it is doctors, nurses and managers who form the core of the health service. The relatively small group of doctors control access to the service as well as diagnosis and treatment. They suggest a lack of conventional management has made the medical discourse powerful in the sense that the doctors can argue for resources from a perspective that the managers can not. As they claim “(m)anagers have been weak because doctors have been powerful; nurses have been ignorant because doctors have been educated” (Strong and Robinson, 1988:xi). The key to nursing’s future positioning in the health care system, they assert, is linked with education, the locus of which must be outside the constraints of the health system. In this sense, education can be considered in terms of what Foucault (1982) refers to in his notion of “practices of freedom”.

However, the most recent health ‘reforms’ and their impact on disestablishing nursing hierarchies and structures, seem to have affected nurses in the sense of

security once provided by hierarchical structures and ritualistic authoritarianism which many practising nurses were socialised into and have been part of. This hierarchy provided for a well established career structure for nurses who, at the start of their training as a nurse at the age of eighteen, could aspire to move through various nursing positions over a number of years to become a chief nurse (as was the experience of the writer). In many hospital environments there are no longer charge nurses, supervisors, assistant principal nurses, principal nurses and chief nurses. The emphasis in the clinical environment is now on clinical practice where generic managers manage nurses and the charge nurse has, in many instances been replaced by a team leader - a concept which Hugman, (1991) identifies has been borrowed from social workers. The role of the former chief nurse is no longer one of management but exists in an advisory capacity, and in some situations, has a leadership role. But this is lamented by nurses who believe that nursing as an occupation or profession has lost control of its destiny.

It can also be said, however, that nurses may have lost opportunities to become autonomous practitioners in one sense by seeking to have hierarchical structures perpetuated. Over the last eight years at least, there have been numerous changes to the management of the health service, but of hospital services in particular. The State Sector Act 1988 was the enabling legislation for general management to replace the previously long-held tradition of triumvirate management, in which the nursing, medical and administration areas were managed separately by a nurse, a medical practitioner and an administrator respectively. For nurses, the introduction of general management meant that there was one general manager for what were now Area Health Boards - an iteration of Hospital Boards - and nurses no longer managed nurses, although it could be said that nurses managed nursing (Williams, 1996). Where nurses and nursing were positioned within this triumvirate management model, however, is worthy of comment. This model was in effect, a

pyramid, in which the medical practitioners, the doctors, were at the apex. As Strong and Robinson (1988) identify, below the group of doctors at the apex of the pyramid; actually a small number of consultants, were the support staff. Vast numbers of workers, including nurses, were actually there to support the work of this small group of medical practitioners. The general management model shattered this empire and replaced it with a new framework in which all staff, but in particular medical and nursing staff were subordinated to managers. The deconstruction of the nursing hierarchy that accompanied the introduction of general management seems to be what nurses continue to grieve for (Bickley, 1992; Wilson, 1995).

The election of a National Government in New Zealand in November 1990 heralded further changes in the already tenuous position of nurses in the health care environment. In 1991, Simon Upton, as Minister of Health released a document called *The Green and White Paper* which outlined the intention of extensive dismantling of the existing structures in health and comprehensive restructuring. Thus the enemy for nursing and nurses was not now the general management model but the commercial model, on which the health reforms were predicated. Fourteen Area Health Boards which existed in 1990 were disestablished, and in their place, 23 Crown Health Enterprises were created in which the position of nurses was to be even further subordinated. Added to this, was a change to the funding of the health services. Regional Health Authorities were created to purchase health services from providers, which were, in the main, the Crown Health Enterprises. Many nurses left nursing. The Employment Contracts Act (1991) meant that national awards for nurses no longer existed and workplace bargaining for collective contracts took the place of these national awards. This had repercussions for nursing education. No longer was there the security of finding employment soon after graduating from an educational course. Newly graduated nurses, unable to get permanent positions left New Zealand for employment

overseas. But the polytechnics, nonetheless continued to shift to undergraduate nursing degrees. In 1992 when three polytechnics commenced degrees and 1500 new graduates went onto the job market in 1994, employment for these nurses was not immediate. It is difficult to determine exactly how many positions were later taken up in the workforce by new graduates, as there is no data to substantiate where they went to following registration.

Just as Foucault asks the question “Who are we?” nurses seem to be confused with their identity. Nursing seems to have lost its way as a result of the health care reforms in New Zealand. It may be more appropriate to consider how the nurse could be repositioned within a reformed environment through strategies that focus on the creation of a different nursing identity - one that is not defined by others, and one which does not have to function within the constraints of hierarchical structures associated with hospitals.

Staking a claim for the future: possibilities for resistance

Foucault identified three types of struggles in society: first against forms of domination, secondly, against forms of exploitation, and thirdly, against what tied individuals to themselves, thus submitting individuals to others in this way. These, he claims are “struggles against subjection, against forms of subjectivity and submission” (Foucault, 1982:212). Thus, in his view of power, to get to the essence of these struggles, he suggests

In order to find out what power relations are about, perhaps we should investigate the forms of resistance ... they are struggles which question the status of the individual : on the one hand they assert the right to be different, and they underline everything which makes individuals truly individual. On the other hand, they attack everything which separates the individual, breaks his links with others, splits up community life, forces the individual back on himself and ties him to his own identity in a constraining way (Foucault, 1982:211-212).

Foucault (1982) recognised that he may have focussed excessively on technologies of domination in relation to power. He shifted his interest to the interaction between oneself and others in technologies of individual domination, as a way of addressing these struggles. Through use of the notion of technologies of the self he illustrates how the individual acts upon oneself in creating a particular subjectivity, and identification of such practices of the self can also identify opportunities for resistance to particular subjectivities. Thus in this sense, as James Marshall (1989:109) points out

we do not have to have a total world view to resist and oppose forms of political subjection and domination; we can do it at any time... The problem is to recognise when modern power is being exercised and whether, when it is being exercised, resistance is the appropriate response.

According to Roberts (1983), the nursing identity has been located within the notion of what is referred to as an 'oppressed group'. The emphasis of this notion is on who has power and who doesn't. Within this framework, power is seen as repressive, and not as Foucault sees it, that is, as productive. Foucault's view of power emphasises that we "should not assume a massive and primal condition of domination, a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations of domination" (Foucault, 1980:142). Thus his challenge is to think beyond emancipatory projects predicated on modernist notions of power. He critiques the totalising features of emancipatory social theories and emphasises instead, a micropolitics of resistance. This highlights one of the limitations of critical theory in that it suggests, through the notions of empowerment and emancipation, the existence of oppression. In this respect, Cleo Cherryhomes (1988) cautions that critical theory is limited in relation to emancipation, and identifies a need for poststructural analysis to address power relations.

Equally, as there can be criticism of the effects of humanism in the construction of the nursing identity, this needs to be put into context of the underlying poststructuralist methodology utilised in this thesis. As Weedon (1987:32) notes

Humanist discourses presuppose an essence at the heart of an individual which is unique, fixed and coherent ... poststructuralism proposes a subjectivity which is precarious, contradictory and in process, and constantly being reconstituted in discourse each time we think or speak.

Attempts to reposition nursing through the discourses of humanism, which posit metanarratives about caring need to be considered with caution in the sense that they suggest a common identity for the nurse. Additionally, as Sawicki (1991) points out, for Foucault, resistance is also resistance to humanism. Allen (1985) warns against becoming locked into one view, one answer, or one method of knowledge development in nursing. The generic message in this is that criticism is essential, and that this is the challenge for nursing. Foucault places the responsibility for critique on each individual when he asserts

It is not therefore a question of there being a time for criticism and a time for transformation, nor people who do the critiquing and others who do the transforming, those who are enclosed in an inaccessible radicalism and those who are forced to make the necessary concessions to reality. In fact I think the work of deep transformation can only be carried out in a free atmosphere, one consistently agitated by a permanent criticism" (Foucault, 1981:155).

John Rajchman (1991:11) explains the significance of Foucault's critical thought when he says that it can "... analyze what we did not realize what we had to say and do to ourselves in order to be who we are".

This thesis has identified that the nursing identity is shaped by a number of different and often competing discourses, within power relationships. The emphasis in this thesis has been one of critique, informed in the main by a Foucauldian perspective.

It has not addressed nursing education beyond the level of preparation of the nurse for registration, and this can be identified as a limitation of this thesis in that it does not provide an overall picture of the nursing profession. The issue of post-registration education in relation to the nursing identity may be a topic which might build on the work of this thesis, and for some one else to pursue.

One of the risks in adopting and adapting the insights of Foucault is that of this thesis being seen to be procrustean.¹ By this is meant the use of some arbitrary method by which to fit the argument of this thesis to conform to Foucault's views. However, this can be rejected in the reassurance provided in the words of Foucault (1980:65) who said

If one or two of these 'gadgets' of approach or method that I've tried to employ with psychiatry, the penal system or natural history can be of service to you, then I shall be delighted.

That does not mean there are no limitations to this thesis. In that it has been underpinned throughout by an assertion that there is a relationship between the nursing identity and nursing education in terms of a network of power/knowledge relations and discourses within which regimes of truth can be identified, that claim needs to be substantiated. Sociopolitical forces which exist in networks of power have been identified and analysed; however, these may be incomplete and some may have been overlooked.

¹ In Greek mythology, Procrustes - also referred to as Polypemon or Darmartes - was an individual who hijacked travellers on the road to Athens. He invited them to spend the night at his house, but tied them to a bed. If they were too large for the bed, limbs were amputated; if too short for the bed, limbs were stretched (Comte, 1991).

Last words

Foucault (1984) reminds us that the subject has no core identity, but is produced through different power relationships. The same can be said for the nursing identity. The subjectivity of the nurse is defined by the dominant discourses of society, so the nursing identity is defined by others. To resist this, it needs to be understood how subjectivity is created through such discourses, and how counter-discourses can be created. In this regard midwives have been able to counter the discourse of medicalised childbirth through the development of a midwifery discourse (Papps and Olssen, 1997). Nurses, it must be argued, cannot reposition their identity through the discourse of industrialism, since this does not provide a counter discourse in terms of how power is exercised. The 'truth' claims of such a discourse do not provide a counter discourse that can address the difference between the nursing identity as someone where the emphasis is on 'doing' and the nursing identity as someone who is a 'thinker'. Systems of differentiations and dividing practices, as well as association with the assumptions of the biomedical model from which there is some reluctance to shift, has located the nursing identity firmly within the discourse of medicine, so that as Street (1992) identifies, medicine is the dominant discourse of nursing. Nursing education may be able to ensure that the nursing identity does not continue to be what Belenky et al (1986:134) identify as a "...sense of self ... embedded in either external definitions and roles, or in identifications with institutions, disciplines or methods".

Foucault makes reference to the role of the specific intellectual. He is careful to point out that "(t)hey do not formulate the global systematic theory which holds everything in place, but analyse the specificity of mechanisms of power...the project, tactics and goals to be adopted are a matter for those who do the fighting. What the intellectual can do is provide instruments of analysis, and at present, this is the historian's essential role" (Foucault, 1980:62).

This, then, is the contribution of this thesis: the unravelling of the power relations in which the nursing identity is constructed is an instrument of analysis. It has been argued that various disciplinary regimes produce the nursing identity. This has been explicated through utilisation of Foucault's notions of technologies of power. Technologies of domination operate in the sense that the nursing identity is constructed by others within institutionalised power relations. Their purpose is to define and control the conduct of others (in this case, nurses) and to submit them, through the exercise of power, to lead useful and docile roles. The disciplinary practices of technologies of domination can be seen in the way that nurses are disciplined through legislation at a macro-level. This creates a 'governable' identity or subject, and is reinforced within institutional structures through mechanisms of normalisation.

The nursing identity is also constructed through technologies of the self. Thus a particular nursing identity or subjectivity is perpetuated. In this respect Foucault's comment is poignant: "(p)eople know what they do; they frequently know why they do what they do; but what they don't know is what what they do does" (Dreyfus and Rabinow, 1982:187). Freedom to develop new kinds of subjectivity may only come about through the recognition of power relations, and with the realisation that power is not oppressive, but productive. Wherever there is power, there is resistance, thus the power relations that construct the nursing identity contain the possibility of liberation. The nursing identity as defined by the truth claims of others is something to be liberated from. In this sense, to be who we are, we must refuse who we are.

APPENDIX ONE

ESTABLISHMENT DATES OF COMPREHENSIVE NURSING
COURSES IN NEW ZEALAND POLYTECHNICS

1973	Christchurch, Wellington.
1974	Nelson.
1975	Auckland.
1978	Southland, Waikato.
1980	Manukau, Manawatu.
1981	Hawkes Bay.
1982	Taranaki.
1983	Northland.
1984	Otago.
1985	Wairariki.
1986	Carrington, Porirua.

Department of Health (1988) *Nursing education in transition*, pages 20-21

APPENDIX TWO**RECOMMENDATIONS FROM REVIEW OF THE PREPARATION
AND INITIAL EMPLOYMENT OF NURSES, 1986**

- (1) development of co-ordinated national health and nursing workforce policy and associated planning,
- (2) definition of the scope and practice of nursing and the relative role and function of first and second level nurses,
- (3) provision of equitable access to nursing courses through affirmative action for targeted groups (in particular Maori and Pacific Island people),
- (4) promotion and marketing of nursing:
 - to inform the public of the role and function of the nurse,
 - to recruit new entrants to the profession,
 - to recruit and retain qualified nurses into health and nursing education services,
- (5) provision of adequate financial support for nursing students in technical institutes,
- (6) development of curriculum, including consultative and monitoring procedures to ensure that the needs of the health service are met,
- (7) maintenance of a qualified nurse-teacher workforce,
- (8) rationalisation of relationships within the tertiary sector - universities and technical institutes,
- (9) development of a research resource committed to promoting research in all aspects of nursing and the dissemination of research findings,
- (10) re-appraisal of the nurses working environment including structure, management and conditions of employment,
- (11) improvement of methods of induction and orientation of new graduates into the workforce with special reference to the transition phase,
- (12) improvement of recruitment of new graduates into specific service areas, for example psychiatric, psychopaedic and long term care areas,
- (13) promotion of a bicultural attitude and multicultural sensitivity within the health service,
- (14) promotion of improved systems of communication between the users and the providers of the health services and between the health and education sectors,
- (15) development of processes for sharing skilled personnel in the health and education sectors,
- (16) facilitation of the completion of the transfer of nursing education into technical institutes.

(APPENDIX TWO - continued)

It was recognised that underpinning the recommendations arising from these issues three conditions must exist:

- the development of a national health policy to provide an informed base for determining/defining the nursing component within the health system. A bicultural approach with multicultural sensitivity is an essential and integral part of such a policy. The policy would determine the emphasis to be placed on the preventive, health promotive and health maintenance services and the caring, curative sectors of the health services and give direction for the preparation of an adequately prepared nursing workforce,
- a spirit of co-operation and goodwill by all parties in the endeavour to provide a health service that meets the needs of our society,
- recognition that action on the recommendations will require allocation or re-allocation of financial resources to underpin all activities within the education and nursing services and that this condition be drawn to the attention of the relevant authorities.

Department of Health (1986) *Review of the preparation and initial employment of nurses*, pages 34-35.

APPENDIX THREE**NEW ZEALAND QUALIFICATIONS AUTHORITY
CRITERIA FOR THE APPROVAL OF DEGREE PROGRAMMES**

Approval for a degree programme will be given by the New Zealand Qualifications Authority subject to the following criteria:

- 1 The programme meets the definition of a degree as specified in the Education Amendment Act and by the Qualifications Authority.
- 2 The programme is described in terms of learning outcomes.
- 3 The programme is accepted in the wider academic community as being worthy of approval.
- 4 a The organisation of the programme promotes appropriate self-directed learning and achievement.
b The programme is structured to provide a sound and balanced academic progression.
c The programme provides components of knowledge and skills acquisition, problem solving, and research appropriate to each subject and level in the programme.
d Assessment procedures are well documented, pedagogically sound, relate to the programme's objectives and are understood by the students.
e No aspect of course delivery creates unreasonable barriers to access.
- 5 The programme is modular where appropriate and units are cross-creditable with other programmes.
- 6 a The programme is able to achieve and maintain comparative equivalence with other New Zealand (or international) degree courses at this level in this subject or field.
b Prerequisites and admission requirements are appropriate and fair.
c The programme provides an explicit foundation for further study and research.

APPENDIX FOUR

VISION 2000 COMMITTEE

A FRAMEWORK FOR NURSING/ MIDWIFERY EDUCATION

Introduction

The Vision 2000 Committee originated from a meeting of interest groups at the New Zealand Nurses Association's 1990 annual conference in Wellington. The groups included the Nurse Educators in the Tertiary Sector, the Chief Nurses of New Zealand, the New Zealand Nurses Association, the Nursing Council of New Zealand and the Department of Health. For these groups, the most important issue was the impact on nursing and nursing education arising from massive restructuring of the health and education sectors in the absence of a developed national framework for nursing and midwifery education. A steering committee, representing the groups at the conference plus a representative of the New Zealand College of Midwives, was formed and initially called the Forum Planning Group.

The original goal of this group was to develop a national framework for nursing and midwifery education with targets, guidelines and strategies to establish shared ownership of education targets.

The first step was to organise a national forum where all interested groups could debate nursing and midwifery education issues in New Zealand. The forum, known as Vision 2000 Project 1991, attracted wide support and was attended by over 260 people.

A small group analysed the outcomes of the forum and recommended that a national group be formed to pursue the objectives of the Vision 2000 project.

The Forum Planning Group, which then became the Vision 2000 Committee, decided to try and work on the exercise itself before forming the national group.

The committee began by publishing the forum and pre-conference papers. "Papers Presented at Vision 2000: Project 1991 Forum on Nursing and Midwifery Education March 14-16 1991" was published in July 1991.

The committee then commissioned the preparation of a discussion paper, "A Framework for Nursing and Midwifery Education in New Zealand", to extend the debate on the possible content of a framework. This was published in January 1992 and drew a large number of submissions by March 1992. At this stage the New Zealand College of Midwives withdrew from the committee.

The submissions were analysed and taken into account by the Vision 2000 Committee prior to the preparation of this paper. It is hoped that this framework for nursing and midwifery education will be widely read and acted on.

The final responsibility of the Vision 2000 Committee before it formally disbands will be to endeavour to form a national group to provide ongoing direction and action for nursing and midwifery education.

Underlying assumptions about the nursing/midwifery profession

- Nursing/midwifery is practised by those qualified through education and experience.
- The scope of practice to address health needs is defined by the profession in the public interest.
- The profession, in order to meet its commitment to society, is obligated to regulate the practice of its members and promote excellence in practice.
- Decisions about professional education are made by nurses/midwives in collaboration with the education service and their consumers, the community and the profession.
- The profession determines and monitors the framework of all qualifications.
- Education is fundamental to the ongoing competence of practitioners.
- Nurses/midwives with different qualifications contribute to the scope of professional practice.
- Scholarship and research are the cornerstones of the development and maintenance of quality in practice and the education of practitioners.
- The profession in New Zealand is part of the international nursing/midwifery community.
- Nurses/midwives are accountable for their own competence to practise and have a responsibility to use educational opportunities to ensure competence.
- The framework of educational programmes expresses the professional vision of nursing/midwifery's contribution to quality health care and the shaping of the health service.
- Educational programmes for nurses/midwives acknowledge the need for diversity in practice.

Education for the shaping of health care

The willingness of the profession to respond to society's needs underlies the mandate to practise. The context of nursing and midwifery practice in New Zealand includes the direct relevance of the Treaty of Waitangi, the Government led health and education reforms, demographic changes, and international developments in health care needs.

Nursing/midwifery education should take into account the Treaty of Waitangi, national and international developments in health care and education and demographic changes.

Commitment to the public interest motivates the profession to contribute to health policy development. Collaboration between professionals, policy makers and consumers is the way to identify health goals at national and regional levels.

Nursing/midwifery education

should prepare nurses and midwives to participate in local and national policy development in health care and education.

Workforce planning needs to take into account that a professional nursing/midwifery service must be provided to those who need it.

The public's need for the professional care provided by nurses and midwives requires the profession to participate in health policy development. Nurses and midwives provide professional care within a framework of professional accountability.

The prerequisite for full participation in policy making is clear professional leadership. Nursing and midwifery organisations must develop ways of working together to develop, present, support and initiate policies to shape the health service through nursing and midwifery education and practice.

Allocation of resources for nurse/midwife education should be based on advice from nurses/midwives.

Nurses/midwives should be appointed to senior positions within government to provide advice on nursing/midwifery education.

Nursing and midwifery organisations must work together to shape the health service through professional education and practice.

Because general health assistants contribute to the care defined within professional nursing practice, nurses initiate and participate in the development of their educational (training) programmes, and in association with other health professionals, determine their scope of practice.

Nursing education programmes and care giver programmes should be led and controlled by appropriately qualified, experienced registered nurses.

Education to support career

Professional nursing and midwifery practice focuses on people's health needs. It has the potential to cross the boundaries of traditional health care settings by integrating primary, secondary and tertiary care.

Educational programmes support diversity in practice that ultimately fosters new and different ways of delivering health care.

Partnership between service providers and educational organisations is the key to the development of workforce planning and career opportunities.

Educational programmes should be linked to provide a cohesive framework which supports a diversity of career paths and practice which responds to the

health needs of New Zealanders.

Flexible educational programmes for nurses and midwives at undergraduate and post-graduate level are required for the continued development of practice/research, health services and policy, management of nursing/midwifery practice and teaching at all levels.

Education for entry into professional nursing/midwifery practice

In the practice of nursing/midwifery, public safety is paramount and must be legislated for to protect the public interest.

Entry to the practice of nursing/midwifery should be determined by safety to practise — safety having been assessed within a framework of established standards and criteria.

Entry to the practice of nursing/midwifery should be regulated by statute through the recognised regulatory body. (Nursing Council of New Zealand).

The standards and criteria used to assess the safety to practise nursing/midwifery should be the responsibility of the statutory regulatory authority.

The health environment is changing, dynamic and complex. To meet the health needs of the public the

educational preparation of nurses/midwives must provide the knowledge and expertise to reason, research, review, and act autonomously.

The bachelor degree is to be progressively introduced from 1992 to replace existing pre-registration programmes; the transition should be completed by 1997.

Entry to practice for registered nurses and midwives should be via an undergraduate nursing or midwifery degree in an approved educational institution.

For those seeking initial entry to practice and for those registered nurses/midwives seeking a further qualification, educational preparation should include recognition of prior learning.

Enrolled nurses are making a valuable contribution in many areas

of the health service. However, current enrolled nurse preparation no longer appears appropriate due to the rapid and ongoing changes in society and the health care sector.

The Nursing Council of New Zealand should initiate a review of the preparation and role of the Enrolled Nurse with a view to determining:

the relevance of the current preparation to future health service needs

the contribution to nursing practice

the advisability of continuing the Roll of Nurses.

Innovative and flexible educational programmes, recognising prior learning, should be developed to assist the enrolled nurse to gain registration as a nurse/midwife.

Education for maintenance of professional competence

Professional competence is dependent on a commitment from individual practitioners and the profession as a whole.

Continuing education in the form of updating skills and knowledge for registered/enrolled practitioners should continue to be offered by educational institutions.

The employer has a responsibility to the public to employ competent practitioners and therefore has an important role in facilitating ongoing competence.

Employers should make public their policies for orientation, inservice education, and study leave to facilitate ongoing competence of employees.

A variety of methods are used to

ensure the ongoing professional competence of practitioners.

The Nursing Council of New Zealand should establish and maintain a system of regulating competence in consultation with the profession and the public.

All newly registered/enrolled practitioners, or those practitioners entering a new area of practice require orientation.

Orientation programmes should be available in all work settings to ensure safe competent practice.

Preceptorship is an essential component of orientation for new practitioners to any setting. Recognition of the importance of the role of preceptor through further education is required.

Preceptors should be appointed by employers to ensure competence of those undergoing orientation.

Practitioners entering private practice should ensure orientation, ongoing support and mentorship through personally organised structures. Educational institutions should provide advanced education for preceptors in nursing practice and education.

Practitioners are responsible for presenting to employers their credentials for practice as the basis of their contract of employment.

A personal professional profile should be used as a base-line record of competence to practise, career progression and recognition of standards of excellence.

Development of the profession and its body of knowledge

Development of the body of professional knowledge requires the integration of nursing theory, practice and research. Graduate level study (including masters and doctoral degrees) addresses:

- the place and nature of nursing/midwifery
- theoretical frameworks for innovation in practice
- health policy development and health issues as they arise.

Graduate programmes in universities need to be expanded to develop scholarship and research in nursing/midwifery and health issues.

Development of the profession and its

body of knowledge requires collaboration between educational programmes at undergraduate and graduate levels at polytechnics and universities.

Structures should be established to provide for collaborative discussion, planning and evaluation of programme development between institutions.

Research to develop the body of nursing/midwifery knowledge is an integral component of education.

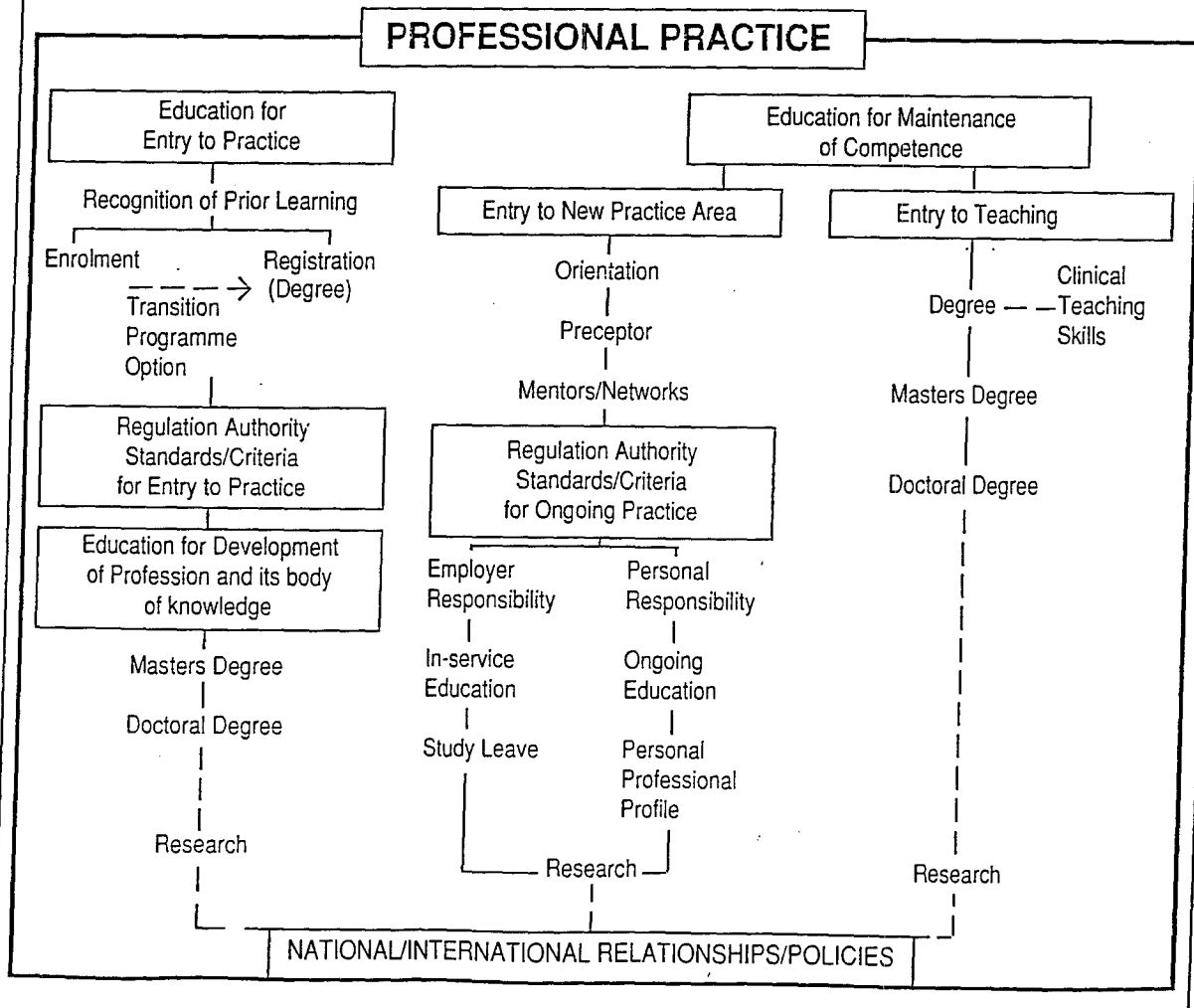
Research units that link education and practice should be established, including research teams led by nurses with higher degrees in nursing. Mechanisms should be put in place for critical review of research by the profession.

Graduate nursing/midwifery education programmes provide for the academic preparation of all teachers of nursing/midwifery to levels beyond that of the students they are teaching.

Teachers in nursing/midwifery programmes should have advanced academic qualifications in the theory and practice of nursing/midwifery.

International educational networks provide for collaboration in teaching and research, linking the profession within the global nursing/midwifery community.

International networking for the exchange of resources and ideas needs to be further developed.



APPENDIX FIVE
NURSING CONSENSUS CONFERENCE 1995
STATEMENT

THE FIRST YEAR OF NURSING PRACTICE

In March 1995 120 nurses - from practice, education and management, from the private and public sectors, from the hospital and the community, and from professional groups - gathered in Auckland. For two days they explored the many issues associated with the first year of practice following registration from five perspectives:

- * INVESTMENT - the stakeholders and their contributions
- * COMPETENCE - preparing for registration
- * TRANSITION - becoming an experienced practitioner
- * SAFETY - creating a safe practice environment
- * PROFESSIONHOOD - fostering quality practice

The statements which follow reflect the discussion which took place and summarise the views expressed by the participants.

THE ISSUE

In 1973 the first nursing programmes leading to registration as a nurse commenced in polytechnics. There were two main reasons for the change: to redress the clearly identified problems associated with hospital-based programmes and to ensure that the community received nursing from qualified nurses. However, when the first graduates entered the workforce as registered comprehensive nurses in 1976 it soon became evident that there were gaps between their expectations and the reality of the practice environment. Initially, most nursing services provided an orientation programme and the additional skill training necessary for safe practice in a specific setting. Over the years, good intentions and well designed programmes have often been undermined. Now, despite frequent debate and recommendations from a variety of sources, new graduates are not always given effective support in their practice setting and, as a consequence, retention and recruitment problems persist. The profession and society cannot afford the avoidable shortage of experienced and potentially experienced registered nurses embodying the characteristics of professionhood at a time when they are needed more than ever before.

1. INVESTMENT

There are many people/groups who can claim to be stakeholders in nursing practice including: students of nursing and their families, people who have a need for nursing, nurses in practice and education, government and private agencies, union and professional groups, and other health care provider groups. Each contributes to the complex context in which nurses practice and students learn.

1.1 It is acknowledged that:

- a) there are multiple stakeholders with an interest in the new graduate's first year of practice
- b) new stakeholders are emerging as a consequence of changes in the health and education sectors
- c) the contributions and expectations of each stakeholder arise from personal values and agendas associated with the context in which they exist
- d) the nursing profession has an ongoing responsibility to identify the various stakeholders and inform them about the profession's expectations of the new graduate
- e) stakeholders have a responsibility to identify their specific expectations of the new graduate and to discuss these with nurses, especially those responsible for curriculum development and for setting competency standards for the beginning registered nurse

1.2 It is agreed that:

- a) beginning practitioners encounter many, and often unrealistic, expectations of their practice abilities during the first year of practice
- b) there is a limited understanding within the profession of the current structures and factors which influence nursing education
- c) there is a limited understanding within the profession of the direction and rate of change occurring in health agencies and the impact on nursing programmes
- d) the first year of practice is vitally important for the beginning practitioner, the profession and the service nursing offers to the community
- e) each person lost to nursing in the first year of practice is a loss to all the stakeholders
- f) the structures and processes which support a clinical career pathway guide the development of the new graduate during the first year of practice
- g) ongoing consultation and collaboration between nurses in education and service is essential throughout the undergraduate programme and during the transition process in order to avoid unnecessary wastage and personal damage to the beginning practitioner
- h) the first year of practice must be viewed as a year of nurturance and learning for the beginning practitioner

2. COMPETENCE

During the approved undergraduate programme students undertake a broadly based introduction to the role of the nurse. Safety to practise is demonstrated by the achievement of predetermined competencies. Nurses in education and in practice have a responsibility to ensure that each nurse seeking registration has achieved the required competency standards and is ready to practise as a registered nurse.

2.1 It is acknowledged that:

- a) the undergraduate nursing curriculum is a broadly based programme which cannot prepare the student for the specifics of practice in every area
- b) at present there is no common understanding of the dimensions of competent practice in the beginning registered nurse

- c) there is an urgent need to identify a set of national standards or competencies which the student must demonstrate prior to admission to the register and which are achievable within the approved undergraduate curriculum
- d) completion of an undergraduate nursing programme and registration as a nurse are complementary but separate activities
- e) the selection of practice experiences for students is influenced by changing patterns of care delivery including such factors as the increase in day surgery, reduced length of stay, rising average acuity in in-hospital patients, increased technology, new therapeutic regimes, and more community based care
- f) creative approaches to the restructuring of learning experiences involving patients will be necessary to maintain quality experiences for students and meet the competency standards required for registration
- g) the completion of the minimum number of hours required for registration is only one indicator of the student's readiness for practice

2.2 It is agreed that:

- a) the education sector is responsible for fostering the development of the student, and creating a learning environment which facilitates the acquisition of the knowledge and competencies specified in the approved curriculum
- b) the service sector is responsible for modelling good nursing practice and creating a learning environment which facilitates the progressive development of the student's practice skills in a variety of settings
- c) every registered nurse has a responsibility to participate in the preparation and orientation of new graduates
- d) nurses in the education and clinical agencies are both responsible for socialising students to meet the expectations of the practice environment
- e) students are responsible for their own learning, for reviewing their own performance, and for working with nurses in practice and in education to optimise the learning possibilities within each practice experience

3. TRANSITION

The first year of practice marks the transition from student to practising nurse. Nursing has no history of internship although preceptorship programmes have been common. The changing health care environment places new pressures on experienced nursing staff as well as the new graduate. It is now essential to review the nature of the transition experience.

3.1 It is acknowledged that new graduates:

- a) are ready and willing to work as beginning registered nurses
- b) want to practise using the full range of knowledge and skills they have already developed during their educational programme
- c) have undertaken a broadly based nursing programme which prepares them to enter practice at beginning level in any nursing setting
- d) do possess the full range of knowledge and skills required to work safely within any setting after an appropriate programme of orientation

- e) will develop best in an environment which encourages openness, mutual support and assistance when required
- f) often feel disillusioned and dissatisfied during their first year of practice, and often question their career choice

3.2 It is also acknowledged that:

- a) the consequences of internship need to be addressed
- b) employers have a right to expect service from new graduates commensurate with their knowledge and experience
- c) the absence of any nationally determined competency standards for the beginning practitioner may contribute to unrealistic expectations of the new graduate
- d) nursing's commitment to the community means that they may have different views on the provision of nursing and health services from those of managers who are not nurses
- e) the changing health care and employment environments require nurses to look critically at traditional work practices
- f) the employment of new graduates in a pool without appropriate orientation and supervision places the patient, nurse and colleagues at an unacceptable level of risk
- g) difficulties associated with the recruitment and retention of experienced nurses in practice settings deprives students and new registered nurses of role models for practice

3.3 It is agreed that:

- a) the members of the nursing profession share responsibility for supporting the professional development of each new graduate in practice
- b) the profession must clarify the language used to describe aspects related to the first year of practice including mentoring, preceptorship and internship
- c) any discussion of provisional registration and a nationally developed "internship" programme is a matter to be decided at a national level by nurses, and linked to professional development and quality care
- d) current experimental models for orientation to practice are valuable attempts to support new graduates and to facilitate their development as employees and beginning registered nurses

and that there is a need to:

- e) determine the impact of changing service goals on nursing practice
- f) identify the characteristics of quality learning experiences in the practice setting for nursing students and actively seek to optimise such experiences in the interest of the profession, the nurse and the learner
- g) identify the factors which influence the effectiveness of orientation programmes for new graduates
- h) evaluate the effectiveness of current innovative models for the first year, their relationship with career development models, and their influence on the nursing profession
- i) identify the competency standards new graduates should work to achieve by the end of the first year of practice

4. SAFETY

The newly registered nurse, the experienced nurses within the work setting, the employer, the Nursing Council of New Zealand, nurses in practice and education, and the profession all share responsibility for ensuring the safe transition from student to practice. Safety of the patient, the nurse and the service cannot be compromised during the transitional phase.

4.1 It is acknowledged that:

- a) nurses are accountable to their community for safe nursing practice
- b) a nurse is legally responsible for her/his practice from the moment of admission to the register
- c) the dimensions of safe practice must be identified and monitored by nurses
- d) the indicators of safe practice are situation-specific and reflect the wide range of nursing settings in which the new graduate may work
- e) maximising the safety of the practice setting for the new practitioner is one element of a professional nursing service

4.2 It is agreed that:

- a) new graduates can work in any practice setting in which there is a planned period of orientation, good practice models and peer support
- b) safe practice requires an environment where people are respected and valued for their contribution to the collective endeavour
- c) there will be variation in the abilities and attributes of new graduates so there must be opportunities for the individualisation of programmes to develop strengths and experience, and to identify and address areas of need

5. PROFESSIONHOOD

Professionhood focuses on the characteristics of the individuals who are members of a profession.¹ It encompasses: a belief that nursing is a socially important service; a sense of collegiality through belonging to the group; an acceptance of shared responsibility for a quality nursing service to the community; a personal commitment to provide the best possible professional service; and a willingness to ensure the continuity of the service by the admission of new members.

5.1 There is a concern that:

- a) changing patterns of work in the health sector are challenging the ability of nurses to provide a quality nursing service to the community
- b) health care providers may fail to recognise and/or acknowledge the complexity of nursing and the skill required to provide a safe, effective nursing service
- c) nursing and nurses are always threatened when cost-cutting is the primary motivation behind changes in the delivery of health care because of the fundamental conflict between economic diversity and nursing's commitment to maximise the quality of peoples' lives

¹ Styles, M.M. (1982) *On nursing: a new endowment*. St Louis: C.V. Mosby.

- 5.2 It is agreed that nurses share the responsibility for a quality nursing service and they can achieve this by:**
- a) articulating nursing's specific contribution to health care
 - b) recognising and valuing the individuality of nurses and the diversity of nursing practice
 - c) maintaining personal competence for practice
 - d) creating a working environment which facilitates the translation of nursing knowledge and skills into a positive experience for the people receiving nursing care
 - e) continually reviewing the scope of nursing practice in response to changes in health care patterns
 - f) encouraging innovative practice, facilitating research and the utilisation of research findings in practice
 - g) building and maintaining structures that nurture the personal and professional development of each nurse
 - h) recognising that all nurses experience a blend of professional and employment initiation during the first year of practice
 - i) maintaining a mutually supportive and collaborative relationship between nursing practice and education
 - j) encouraging and supporting students as they undergo the challenging experience of becoming a nurse during the undergraduate programme
 - k) valuing the new graduate's potential to contribute to the ongoing development of nursing practice
 - l) encouraging students and new graduates to question and challenge current practice as an essential part of their development as a safe, reflective practitioner
 - m) working with health care managers to support the goal of an effective health service, at all times promoting the safety and wellbeing of people within the community

Abridged from:

Nursing Consensus Conference Statement, 16 June 1995, pages 1-7

APPENDIX SIX

NURSING COUNCIL OF NEW ZEALAND COMPETENCIES FOR APPLICANTS FOR REGISTRATION AS A COMPREHENSIVE NURSE

STANDARD TEN

The applicant for registration demonstrates the competencies for safe nursing practice

10.1 Communication

The applicant relates in a professional manner and communicates effectively to support the client through the health care experience.

Performance criteria

The applicant:

- 10.1.1 Takes responsibility for establishing rapport and trust with the client.
- 10.1.2 Ensures that information given to the client is presented in an appropriate and meaningful manner.
- 10.1.3 Responds appropriately to the clients questions, requests and problems.
- 10.1.4 Communicates in a manner that is empowering to the client.
- 10.1.5 Practises nursing in a negotiated partnership with the client when and where possible.
- 10.1.6 Practises nursing in a manner that respects the boundaries of a professional relationship with the client.
- 10.1.7 Communicates effectively with the client in exceptional circumstances.
- 10.1.8 Demonstrates verbal and nonverbal skills of clarification, reflection, affirmation and eliciting within a therapeutic relationship.

10.2 Cultural Safety

The applicant practises nursing in a manner which the client determines as being culturally safe.

Performance criteria

The applicant:

- 10.2.1 Recognises the tangata whenua of Aotearoa (NZ) and honours cultural safety as an affirmation of the Treaty of Waitangi

- 10.2.2 Applies the principles of cultural safety in own nursing practice.
- 10.2.3 Assists the client to gain appropriate support and representation from those who understand the client's culture, needs, and preferences.
- 10.2.4 Recognises the impact of the culture of nursing on client care and endeavours to protect the client's well being within this culture.
- 10.2.5 Recognises own beliefs, values and prejudice that may arise in relation to the client's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability.
- 10.2.6 Practises in a way which respects each client's identity and right to hold personal beliefs, values and goals.
- 10.2.7 Consults with members of cultural and other groups as requested and approved by the client.
- 10.2.8 Facilitates the client's access to relevant systems, services and resources.
- 10.2.9 Acknowledges when ability to provide care is limited by own personal attributes and takes appropriate action to ensure client safety and care.
- 10.2.10 Avoids imposing prejudice on others and provides advocacy when prejudice is apparent.
- 10.2.11 Validates that own nursing practice is culturally safe.

10.3 Professional Judgement

The applicant makes professional judgements that will enhance nursing practice.

Performance Criteria

The applicant:

- 10.3.1 Makes nursing judgements based on current nursing knowledge, research and reflective practice.
- 10.3.2 Uses reflection to analyse and clarify direction for ongoing nursing practice.
- 10.3.3 Responds to challenging situations and learns from nursing practice through reflection in decision making and problem solving.
- 10.3.4 Examines nursing situations and identifies and strategises effective nursing care.
- 10.3.5 Raises questions in the appropriate nursing forum.
- 10.3.6 Initiates and enters into discussion about innovation in client care.

10.4 Management of Nursing Care

The applicant manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge, research and reflective practice.

Performance Criteria

The applicant:

- 10.4.1 Uses an appropriate nursing framework to assess and determine client health status and the outcomes of nursing intervention.
- 10.4.2 Acknowledges the uniqueness of the individual and his or her interaction with others and the environment.
- 10.4.3 Obtains, documents and communicates relevant client information.
- 10.4.4 Assesses and provides individualised nursing care based on appropriate knowledge, research and reflective practice.
- 10.4.5 Prioritises nursing actions to ensure effective and safe nursing care.
- 10.4.6 Performs all nursing interventions safely recognising contextual factors, while demonstrating effective time management skills.
- 10.4.7 Knows own limitations and seeks assistance as necessary.

10.5 Management of the Environment

The applicant promotes an environment which maximises client safety, independence, quality of life, and health.

Performance Criteria

The applicant:

- 10.5.1 Recognises the potential for physical, psychological and cultural risk to all people who enter the health care environment and takes steps to promote safety.
- 10.5.2 Promotes an environment that reduces the risk of cross infection/
- 10.5.3 Adjusts the physical and social environment in order to maximise client well being.
- 10.5.4 Ensures that all equipment used by the client is functional, within reach, and suitable for the purpose.
- 10.5.5 Knows how to access, maintain and use emergency equipment and supplies.

- 10.5.6 Acts appropriately to protect self and others when faced with unexpected client responses, confrontation, personal threat or other crisis situations.
- 10.5.7 Determines action to prevent and maintain emergency and disaster situations.

10.6 Legal Responsibility

The applicant practises nursing in accord with relevant legislation and upholds client rights derived from that legislation.

Performance Criteria

The applicant:

- 10.6.1 Complies with legislation that impacts on nursing practice within the specific health care setting.
- 10.6.2 Respects the client's right to access information.
- 10.6.3 Practises in accordance with relevant legislation and codes.
- 10.6.4 Ensures that the right to complain, refuse treatment or any part of care is exercised by the client without fear of recrimination, penalty or withdrawal of physical or emotional support.
- 10.6.5 Ensures that the legislation governing medicines is upheld.

10.7 Ethical Accountability

The applicant practises nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities, culture and choice.

Performance Criteria

The applicant:

- 10.7.1 Applies appropriate ethical principles in nursing practice.
- 10.7.2 Recognises the client's right to choices and when relevant accords to clients opportunities for self determination in all aspects of nursing care.
- 10.7.3 Ensures that each client is fully informed to maximise the potential for decision making and choice.
- 10.7.4 Respects the client's right to live and die in dignity.
- 10.7.5 Respects a client's right to participate in an activity that may involve a degree of risk of which the client is fully informed, and takes steps to minimise the risk.

- 10.7.6 Involves an advocate when the client requests support or has limited abilities in decision making.
- 10.7.7 Ensures the client's right to privacy.
- 10.7.8 Appropriately challenges health care practice which could compromise client safety, privacy or dignity.

10.8 Health Education

The applicant assists clients and groups to achieve satisfying and productive patterns of living through health education.

Performance Criteria

The applicant:

- 10.8.1 Recognises the potential for health teaching in nursing interventions.
- 10.8.2 Selects and implements health promotion programmes to meet identified client need.
- 10.8.3 Uses informal or formal methods of teaching appropriate to the individual or group abilities.
- 10.8.4 Prepares the client and/or others for continued health care.
- 10.8.5 Evaluates client learning and understanding about health practice.
- 10.8.6 Recognises own limitations and determines appropriate person to deliver health education sessions.

10.9 Interprofessional Health Care

The applicant promotes a nursing perspective within the interprofessional activities of the health care team.

Performance Criteria

The applicant:

- 10.9.1 Promotes the nursing contribution to health care.
- 10.9.2 Values the role and skills of all members of the health care team including those of the client.
- 10.9.3 Attempts to establish and maintain effective collegial relationships.
- 10.9.4 Co-ordinates care to maximise health for the client.
- 10.9.5 Collaborates, consults and refers to maximise health gains.

- 10.9.6 Documents appropriate nursing information and communicates this to other team members.

10.10 Quality Improvement

The applicant contributes to ongoing quality improvement in nursing practice and service delivery.

Performance Criteria

The applicant:

- 10.10.1 Identifies organisational goals and the nurse's contribution to their achievement.
- 10.10.2 Practises nursing in a manner that reflects organisational goals and policies.
- 10.10.3 Identifies professional nursing networks and support systems.
- 10.10.4 Practises nursing in a manner that meets relevant codes and standards.
- 10.10.5 Identifies evidence which contributes to an evaluation of the quality of nursing practice and service delivery.
- 10.10.6 Ensures that nursing tasks are delegated to those who have the necessary skill, information and education to perform the task effectively.
- 10.10.7 Takes responsibility for own actions and outcomes of nursing care planned and delegated.

10.11 Professional Development

The applicant undertakes responsibility for own professional nursing development and contributes to the development and recognition of professional nursing practice.

Performance Criteria

The applicant:

- 10.11.1 Articulates values, beliefs and assumptions that underpin own nursing practice.
- 10.11.2 Recognises own level of competence and identifies direction for ongoing professional development.
- 10.11.3 Identifies goals for personal learning within the clinical setting.
- 10.11.4 Seeks support from colleagues in learning and developing own practice.

- 10.11.5 Recognises expectations and limitations of own nursing practice.
- 10.11.6 Recognises the need for debriefing and when necessary ensures that this is accessed.
- 10.11.7 Evaluates own nursing practice.

Nursing Council of New Zealand. (1996) *Standards for the registration of comprehensive nurses*, pages 15-21.

- * Competencies are defined by the Nursing Council of New Zealand (1996:22) as:
Sets of attributes including the knowledge, skills and attitudes required to perform key functions to the predetermined standards expected of a nurse or midwife in practice.

APPENDIX SEVEN

REQUIREMENTS FOR INCLUSION IN CULTURAL SAFETY -1992

- 1 Racism awareness training - structured course.
2. Treaty of Waitangi training - structured course.
- 3 Decolonisation courses for tangata whenua, as an option.
- 4 Education in:
 - 1 Understanding the pervasiveness of attitudes unconsciously held and unanalysed, and the values which underpin them
 - 2 Discovering the self and examination of own cultural norms.
 - 3 Pakehatanga
 - 4 Understanding how behaviour is shaped by attitude
 - 5 Revisionist New Zealand History
 - 6 The colonial process
 - 7 Political processes and their value bases
 - 8 Social control
 - 9 The causes of violence
 - 10 Urbanisation
 - 11 Demography
 - 12 Unemployment and the poverty cycle
 - 13 Institutional racism and its effect on the development of policy
 - 14 Tikanga Maori, as defined by tangata whenua, Maori nurse teachers and Maori Studies Departments
 - 15 Maori health initiatives
 - 16 Response of iwi Maori, e.g. Tu Tangata and Kohanga Reo and many other Maori social initiatives.
 - 17 The international view.

Education must be broad based and start with self discovery, It must be thoroughly grounded in the students being able to evaluate what they are bringing to the consumer in terms of their own invisible baggage, i.e. attitudes and metaphors, beliefs and values.

Nursing Council of New Zealand (1992) *Kawa Whakaruruhau. Guidelines for Nursing and Midwifery Education*, page 7.

APPENDIX EIGHT

CONTENT OF CULTURAL SAFETY EDUCATION - 1996

Cultural safety in nursing and midwifery curricula is based on:

- the Treaty of Waitangi and its impact upon nursing, midwifery and the development and delivery of health and disability services to tangata whenua and tauwiwi;
- the impact of colonisation upon the health of the people nationally and internationally;
- the impact of inequality, prejudice and discrimination on the health of people for reasons of age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability;
- nursing and midwifery as cultures within the health and disability services;
- the power inherent in the status and role of the nurse and midwife as it impacts in nursing and midwifery practice;
- the application of cultural safety principles to different nursing and midwifery practice settings;
- planned nursing and midwifery experiences that facilitate the development of culturally safe practice;
- the concept of culture as shared meaning, and, therefore, accepting that many meanings are different and not shared;
- the nurse and midwife as a bearer of their own culture;
- the implications of political processes and how these impact upon nursing, midwifery and health and disability service delivery;
- the demographics related to health status and health and disability services;
- the principles and practices of research methodologies acceptable to a range of human groups;
- the concepts of critical thinking and reflective practice;
- the skills of advocacy and negotiation to ensure that consumer feedback contributes to continuous quality improvement in service delivery.

Nursing Council of New Zealand (1996c) *Guidelines for cultural safety in nursing and midwifery education*, pages 14-15.

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