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**Nurse Practitioners in Rural Primary Health Care in New Zealand:  
An Institutional Ethnography**

A thesis presented in fulfilment of the requirements for the degree of

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## Abstract

Nurse practitioners are an effective and appropriate health workforce for delivering health services to underserved and rural populations. Since 2001, New Zealand has been registering nurse practitioners through a robust educational, regulatory, and legislative framework, and from 2014, all nurse practitioners are authorised prescribers. However, the numbers of nurse practitioners working in rural primary health care have been slow to materialise. Despite an ageing demographic, the increasing prevalence of long term conditions, ongoing health inequalities, and a declining rural medical workforce, there remains a persistence to pursue the general practitioner-led model of care.

The purpose of this study was to critically examine the work required to establish nurse practitioner services in rural primary health care in New Zealand. Institutional ethnography, developed by Dorothy Smith, provided the overall approach to the inquiry. The activities and experiences of people in local settings are textually organised by the institutional ruling relations. This inquiry explored the work and experiences that nurses undertook on their journey to become nurse practitioners and deliver services in rural primary health care, and how these were institutionally shaped and coordinated.

Interviews were initially conducted with nurse practitioners and nurse practitioner candidates as the primary informants. The interviews were analysed using a mapping technique to identify text-based work processes and show connections, tensions, and contradictions with authoritative or ruling texts. Further data was collected through secondary informant interviews and the tracing and identification of texts.

The findings revealed that there were multiple texts and discourses being enacted locally, which facilitated or hampered their work to become nurse practitioners. The ongoing institutional domination of medicine retained general practitioner-led primary care, despite policy and nursing professional texts that promoted social justice. Service fragmentation and frequent changes in policy, structure, and management of organisations at local and

national level, resulted in further challenges and work processes by the nurse practitioners to maintain and implement services. Together with the lack of a cohesive national policy and implementation framework for nurse practitioners, the opportunity for nurse practitioners to meet the health needs of the rural population of New Zealand continues to be discounted.

## Acknowledgements

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The seeds of this study began a long while back, and through that time many people have contributed their support, ideas, and stories, both those who I have worked with in multi-disciplinary teams, and those I've met along the way. Thank you.

Thank you also to the team at Te Tai Tokerau PHO: Rose Lightfoot has been a visionary nurse leader for many years, and CEO of the PHO; also to Maree Sharp whose energy to support NPs and NP candidates is extraordinary; and to Hemaima Reihana-Tait, a nurse leader and advocate for Māori health and the provision of nursing services.

To the School of Nursing team at Massey Albany, thank you for your ongoing day to day support and encouragement. You are a fabulous team in which to work. Dr Catherine Cook – you have been a great mentor throughout my doctoral journey. Your ability to help me refocus and ground myself has been essential.

I was truly privileged to attend an institutional ethnography (IE) workshop at the University of Toronto with Professor Dorothy Smith and Dr Susan Turner in 2012, and then to skype in regularly to an IE group led by Dr Janet Rankin. To be in the presence of such great minds is humbling. At Massey we now have our own small IE group and I want to thank you for helping refine my thinking. A big thanks to Rhonda for reviewing my final draft.

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## Reading Notes

Abbreviations, listed on the following page, are used to improve ease and flow of reading. At times through the thesis I restate the full term to assist the reader.

I have chosen to write general practitioner in full (except where given in quotes or data) as 'GP' is often used interchangeably in the literature, and particularly policy documents, with general practice.

Notes are provided throughout the thesis for supplementary information or definitions, including terms that have a particular use in New Zealand.

### Translation of Māori terms used

Māori	the indigenous people of New Zealand, or tangata whenua, which means people of the land
Aotearoa	the Māori name for New Zealand. While several meanings for Aotearoa exist, the most popular is <i>land of the long white cloud</i>
iwi	tribe
hapu	sub-tribe
whānau	family, though in a broader context than the western/English definition of family
Tiriti o Waitangi	The Treaty of Waitangi is the founding document of New Zealand signed between Māori chiefs and the British Crown in 1840

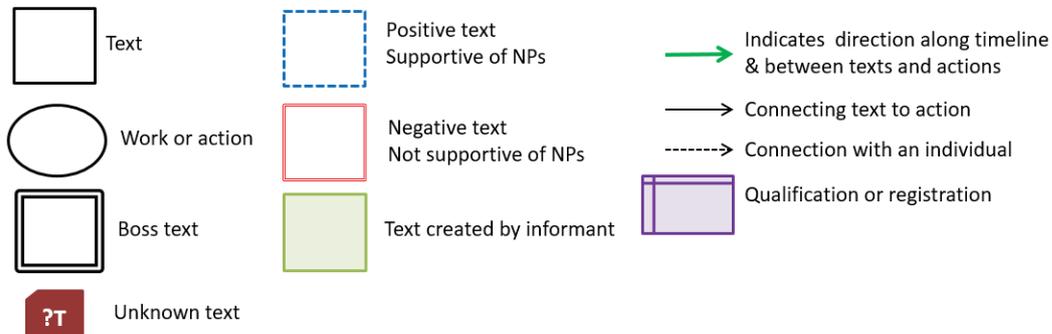
### Referencing Dorothy E. Smith

Given this approach to inquiry is based upon Dorothy E. Smith's work, references to her are given as Smith, rather than D. E. Smith. For example, (Smith, 2005), rather than (D. E. Smith, 2005). I have done this because I believe it helps the flow of the writing.

Other Smiths, who are first authors, are referenced using their initials, eg (G. W. Smith, 1995).

## Mapping Symbols

The mapping symbols used are given below, and I have repeated these at various times in the thesis for ease.



## Permissions

Permissions were granted to include three publications in the Appendices:

- Adams, Carryer & Wilkinson (2015) from Nursing Praxis New Zealand;
- Carryer & Adams (2017) from Collegian and Elsevier;
- Adams & Carryer (2017) from SAGE.

New Zealand Doctor gave permission to use graphics showing capitation before and after 2001 (reference: Topham-Kindley, 2015) (see Figure 5, page 185).

The American Academy of Family Physicians gave permission to use their diagram from their document (2012) comparing family physicians with nurse practitioners in terms of degrees required and completion (see Figures 6 & 7; pages 224 & 225).

## Abbreviations

AAFP	American Academy of Family Physicians
ACC	Accident Compensation Corporation
APN	advanced practice nurse
CEO	chief executive officer
CMA	Canadian Medical Association
DoN	director of nursing
DHB	District Health Board
ED	emergency department
GP	general practitioner
HDC	Health and Disability Commissioner
HFA	Health Funding Authority
HWNZ	Health Workforce New Zealand
IE	institutional ethnography
ICN	International Council of Nurses
IPA	Independent Practitioner Associations
MoH	Ministry of Health
NCNZ	Nursing Council of New Zealand
NGO	non-governmental organisation
NP	nurse practitioner
NPNZ	Nurse Practitioners New Zealand
NZ	New Zealand
NZMA	New Zealand Medical Association
OECD	Organisation for Economic Cooperation and Development
PA	physician assistant
PDRP	Professional Development and Recognition Programme
PHO	Primary Health Organisation
PRIME	Primary Response in Medical Emergencies
RHA	Regional Health Authority
RN	registered nurse
SMO	senior medical officer
UK	United Kingdom
US	US (of America)
WHO	World Health Organisation

# Chapter One

## Introducing the Study: Context and Approach

### Introduction

Globally, governments and health systems are coming under increasing pressure to cope with the growth of long term conditions, health complexity, and health inequalities (Carrier, Doolan-Noble, Gauld, & Budge, 2014; Commission on Social Determinants of Health, 2008; Marmot & Bell, 2012). Internationally, nurse practitioners (NPs) have improved access to health and health outcomes for underprivileged, rural, and indigenous populations (Everett, Schumacher, Wright, & Smith, 2009; Holt, Zabler, & Baisch, 2014; Sangster-Gormley, Martin-Misener, Downe-Wamboldt, & DiCenso, 2011), and there is substantial evidence demonstrating NPs' ability to practice at a clinical level that is at the very least equivalent to general practitioners (Martínez-González et al., 2014; Swan, Ferguson, Chang, Larson, & Smaldone, 2015). Nurse practitioners are well placed to play an instrumental part in delivering on the World Health Organization's (WHO) goal of providing universal health services to all, and reducing social and health disparities.

New Zealand has persisting health inequalities, an ageing population, increasing chronic conditions, combined with an over-stretched or disappearing rural medical practitioner workforce (Matheson & Loring, 2011; Ministry of Health, 2015d, 2016b). Māori<sup>1</sup>, the indigenous people of New Zealand, are disproportionately affected with reduced access to health services, poorer health, and reduced life expectancy (Ministry of Health, 2015d). Yet, general practitioner-led care continues to dominate in New Zealand. Despite the promises

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<sup>1</sup> Sometimes referred to as *tangata whenua*, the people of the land.

of the Primary Health Care Strategy (A. King, 2001), the New Zealand health system has failed to provide equitable access to health services for all population groups (Ministry of Health, 2016c). Nurse practitioners are expert health providers with the potential to meet the health needs of New Zealanders, yet this valuable workforce is largely overlooked by policy makers, funders, and employers.

The purpose of this ethnographic inquiry was to critically examine the work required to establish NP services in rural primary health care in New Zealand. Nurse practitioners are advanced, experienced nurses who, in New Zealand, hold a clinical Master's degree in Nursing, and since 2014 are all authorised prescribers. Registered nurses have been able to register in New Zealand as NPs since 2000 within a legislative and policy framework which supports advanced nursing and prescribing practice. Yet despite this, the numbers of NPs working in rural primary health care remains small, irrespective of ever increasing concerns about the sustainability of the existing rural health workforce and escalating inequalities in health (Carryer & Adams, 2017). At the time of writing there were 251 authorised NPs, with an estimated 50% working in primary health care settings<sup>2</sup>. The intention of this research was to explore how the actions and experiences of NPs were institutionally organised along their career pathways to become registered as a NP, gain employment, and deliver NP services to local rural populations.

Chapters one and two provide the background to this inquiry, setting the scene and the approach. In chapter one I describe how I came to be interested in this project, the aims of the study, and the approach to the inquiry using institutional ethnography (IE). The premise, or ontology, of IE is that our social world is textually coordinated through institutional "ruling relations" (Smith, 2005, p. 10). Smith describes the ruling relations as:

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<sup>2</sup> Information provided on Nursing Council of New Zealand web page <http://www.nursingcouncil.org.nz/>. Data collated 24 Aug, 2017.

[T]hat extraordinary yet ordinary complex of relations that are textually mediated, that connect us across space and time and organise our everyday lives – the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them. (Smith, 2005, p.10)

What we do and experience in our everyday lives is organised institutionally through reproducible texts, which may be visual, oral, or written, and connect us extra-locally with other people in geographically separate local settings. While I focus on IE in more detail in chapter three, here I provide an introduction to IE used in this inquiry as the epistemological and methodological approach.

As part of this introductory chapter, a brief history of the NP project in New Zealand is presented with a description of the regulatory, educational, and legislative framework. Changes to improve these processes have been ongoing throughout the period of my inquiry, and where appropriate, the most recent documents and texts are included. The development of the NP workforce sits within the wider context of the health sector which is overviewed here. Neoliberal and market-oriented policies have shaped health policy in primary health care over the past few decades and continues with the current New Zealand Government. Neoliberal policy examples utilised have included ongoing support of the general practitioner-led practice ownership model, competition over funding and a fragmented contractual environment, an increased emphasis on health technologies, and self-responsibility for health (Cumming, 2011; Gauld, 2009). While policy rhetoric emphasises the need to address reducing health inequalities, current neoliberal policies do little to address the problem, and are more likely to reduce access and quality of care (Dahlgren, 2008; Mooney, 2012). The political climate poses significant challenges for NPs to develop services.

The search and presentation of literature and evidence through chapters one and two began from my standpoint and entry into this inquiry. The first chapter sets the background for

this research, including the regulatory, educational, and legislative framework extant for NPs, and an overview to the New Zealand health sector. In chapter two the development of advanced practice nursing and NPs internationally is described, locating their work within a social justice framework. Health inequalities and rurality in New Zealand are defined. Research is presented that supports the effectiveness of NPs and explores the added value of NP work, historically and through to the present day. Ultimately, the purpose of the first two chapters is to demonstrate NPs as a viable and pragmatic workforce in rural primary health care in New Zealand.

While the focus of the research is on rural health, the thesis has wider application for all primary health care advanced practice nursing development. Nurses are employed to work in primary and community contexts through a range of government and non-governmental health providers, including private general practice. The findings and implications of this thesis are likely to resonate with NPs working outside of the hospital setting, in a range of primary health care settings, including urban and rural environments. Chapter one concludes by providing an overview of the thesis structure.

## **My entry to the research and standpoint**

The NP project has been close to my heart for many years. Having arrived from the United Kingdom (UK) in 2005, where I had been working in rural primary health care at an advanced level, my intention was to pursue my own journey towards becoming a NP. Here, in New Zealand, I worked clinically in urban and rural practices and undertook required further postgraduate courses in addition to my Master's. I found that, in the main, I was unable to utilise my advanced skill set. General practitioners were seen as the key providers of primary health care services, and registered nurses (RNs) were not enabled to work to their full scope of practice. I was surprised by this, given the rigorous development of the NP role in New Zealand that I observed on websites. Despite providing both evidence of the

work of NPs in general practice, and a business case to demonstrate their value and cost-effectiveness, I was not able to convince local general practices to employ me with a view to becoming a NP. At the time, there seemed to be both a lack of understanding of the contribution that advanced nurses could make in primary health care, and a lack of willingness to risk employing and supporting a NP candidate. Instead, they continued to try and recruit general practitioners, raising safety concerns regarding a NP's ability to diagnose and prescribe, and claiming that patients preferred to see a general practitioner. I found this deeply frustrating. Further, I received conflicting messages from other nursing professional organisations, local health organisations, and tertiary education institutions regarding how to develop my NP career. At that time, I could not see any way through the various hurdles and barriers presented to reach my goal of working as a NP within the area I lived.

Instead of pursuing the NP pathway, I moved to be an Associate Director of Nursing (ADoN) for primary health care in the planning and funding team for a large district health board (DHB). Firstly, I actively sought to promote the career pathway and professional development of nurses from new graduate through to NP by implementing a nurse education team to strengthen nursing's contribution to primary health care services. Whilst legislation and policy seemingly supported the NP pathway, in practice the process was difficult, without clarity, and often came with inconsistent advice from individuals and organisations regarding the correct or most appropriate ways forward. As an ADoN, I had the opportunity to hear and discuss such issues both with nurses within the district as well as with nurses and NPs from elsewhere in the country. Further, I sat on the Nurse Practitioner Facilitation Programme steering group<sup>3</sup> funded by the Ministry of Health with

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<sup>3</sup> The work and resources of this programme was funded through the Chief Nurse's Office at the Ministry of Health between 2007 and 2009. It included supporting nurses through their final year of a Master's in Nursing programme to achieve registration as a NP.

the purpose of promoting the NP workforce to planners and funders, managers, and employers, and increasing the number of registered NPs.

Secondly, I worked closely with public health physicians and Māori and Pacific health advisors at the DHB to plan and fund services to meet the health needs of local populations. My knowledge of epidemiology and population health grew, along with the understanding that our ethnically related health inequalities were unacceptable. Additionally, there were specific challenges in rural areas due to the declining numbers of general practitioners, and the access to culturally appropriate health services. My realisation that nurses and NPs could deliver on so many of the health priorities grew and grew. Over time, it became increasingly evident to me that there were many complexities at play. With increasing insight into the health sector as a whole, noting the many organisational and professional bodies engaged to varying extents in the NP project, and from discussions with NPs and potential NPs, this inquiry was born.

The various legislative, institutional and professional organisations, along with the popular nursing and medical press, all had, what I described as, their *finger in the pie* of the NP project in New Zealand. I became interested in the connection between the experiences of the nurses and NPs, and the activities, writings, and discourse, at the institutional level. As I embarked on this research, I found that IE offered an approach to social inquiry that explored the institutional and organisational actions in which I was interested. Institutional ethnography is an alternative sociology where the social world is generally explored from the standpoint of the people in the local situation (DeVault & McCoy, 2012). Indeed, the starting place for this inquiry was from my standpoint and experiences. A researcher in IE takes the position of those who are “being ruled” (Campbell & Gregor, 2004, p. 16), and works on behalf of those people, in this study the NPs, to learn how their practices, activities, and experiences are being organised (Rankin, Malinsky, Tate, & Elena, 2010). By using IE, the researcher is able to investigate how “society organises and shapes the everyday world

of experience” (Smith, 1999, p. 74), in turn offering the opportunity to identify where changes may be most effective. It seemed that using IE as the approach to inquiry would be ideal for exploring the institutional processes in establishing NP services in rural primary health care.

Through my work in general practices, primary health organisations (PHOs), and at the DHB, I had become increasingly aware of the significant health inequalities experienced by Māori and Pacific people, across the majority of health indicators, including life expectancy, access to health care services, avoidable hospital admissions, long-term conditions, cancers, and rates of childhood diseases and abuse (Blakely et al., 2014; Blakely, Fawcett, Atkinson, Tobias, & Cheung, 2005). For a small country with seemingly sophisticated health and welfare systems, it seemed to be a travesty of justice that certain groups of the population, and particularly the indigenous people, were so significantly disadvantaged. The growth and success of nurse-managed health centres in the United States (US) (Hansen-Turton, Bailey, Torres, & Ritter, 2010) further fuelled my interest. Contemporary health care systems, including general practitioner services, designed around westernised biomedical models, where the focus is on the diagnosis and treatment of individuals, primarily through acute episodes of care, are failing to meet the health needs of such people (Came, 2014; Commission on Social Determinants of Health, 2008; Wade & Halligan, 2017).

From the outset of this inquiry, my position included the following. Firstly, that I believed NPs were in a position to make a significant contribution to the primary health care sector, increasing access to health for the population, especially in rural areas. Secondly, that the nursing model of health, with a focus on health promotion, health education, and empowerment, added significant value to the existing health care system; and thirdly, that health inequalities were not being adequately reduced within the current biomedical model of health delivery. Nurse practitioners offered a viable evidence-based alternative. Using IE, this study began initially from my standpoint and then expanded to those NPs who were

“expert insiders” in understanding the problem faced (Rankin et al., 2010, p. 334). The purpose was not to prove nor disprove the value of NPs, only to understand and explicate how the issues, difficulties, and successes they had experienced as they became NPs had been socially organised by institutional processes. However, during my journey through this PhD, my conviction about the value and necessity of NPs was affirmed. By exploring the literature, and meeting and interviewing the RNs and NPs who were the informants in this study, I have arrived at a position where I firmly believe that NPs could and should not only be contributing to our primary health care service provision, but leading it.

## **Study aims**

The purpose of this study was to critically examine the work required to establish NP services in rural primary health care in New Zealand. Despite the implementation of a seemingly comprehensive framework to establish NPs, the inquiry sought to discover how it was taking so long to develop the NP workforce, particularly in rural settings. Ultimately, this project was about learning how New Zealand could be engaging with, and supporting the NP workforce, in order to improve the health and wellbeing of rural populations.

The exploration of tensions that I experienced on my own journey to become a NP left me with the sense of a ‘swirling mass of complexity’ that I was unable to grasp or visualise. While a New Zealand descriptive survey identified the “ad hoc” process of transitioning from rural nurse to NP (Carryer, Boddy, & Budge, 2011, p. 24), the detailed critique and understanding of how things happen as they do was not clear. The ‘how’ seemed to be critical to providing insights that ultimately could improve the process and success of nurses becoming rural NPs.

Using IE as the approach to inquiry, the researcher is able to explore, map, and explicate how the activities of individuals within a social situation and location are organised

textually by the institutional ruling relations (Campbell & Gregor, 2004; S. M. Turner, 2006). From my experiences, it was evident that the ruling relations emanated from a range of institutions, organisations, and discourses, seemingly involved somehow with the NP project. Exploring and mapping at least some of the tensions experienced by the nurses and NPs on their journey to deliver rural primary health care services would provide knowledge about this complex issue. Further, I hoped to capture how some NPs had successfully established rural NP services, and how the discourses and texts they had engaged with facilitated their pathway.

More specifically, the research questions were phrased as follows:

- How do nurses and NPs describe their experience of becoming a NP, gaining employment, and delivering NP services in rural New Zealand?
- How is their experience textually shaped and organised in their local settings?
- How are institutional texts and discourses coordinating and controlling the development of the NP workforce in New Zealand?

Finally, the inquiry intends to add to the body of knowledge of IE, both in critiquing its use within the New Zealand health context, as well as contributing to the international literature.

## **Introducing institutional ethnography: The approach to inquiry**

Institutional ethnography is described by Smith (2005) as an “alternative sociology” (p. 1) for people, and began from her critique of mainstream social sciences where authoritative and generalised knowledge of people’s lived experiences were constructed. Instead, Smith wanted a mode of inquiry that worked from the individual’s experiences and discovered how the ruling relations determined their everyday activities. Rather than create categories

and objectified knowledge of how people behave and act, Smith wanted to explicate how the institutional order determined people's actions. For my study, by using the experiences of nurses and NPs in their practice settings at the local level, the institutional processes and forces that have socially organised and coordinated their work and activities could be analysed and mapped.

Institutional ethnography provided the approach to inquiry which enabled a thorough contextual description and investigation of the problem (Bisaillon, 2012). The central commitment of an IE study is in "*discovering* 'how things are actually put together', 'how things work'" (Smith, 2006b, p. 1). Dorothy E. Smith, the founder of IE, describes what we do in our everyday lives as work (Smith, 1990a, 1999, 2005). "Work" is defined generously in IE as anything that is done purposefully by people that "takes time and effort ... [is] done under definite conditions", and includes much more than only paid work (Smith, 2005, p. 151-152). The work of people in the local setting is coordinated and organised textually by the institutional ruling relations. Exploring what people actually do (or do not do) and what they actually experience, enables the researcher to map and analyse the ruling relations at an institutional level.

Research using IE as the approach to inquiry had not been published in New Zealand in nursing or health research at the outset of my doctoral work. The approach and applicability to nursing research in New Zealand formed a publication (Adams, Carryer, & Wilkinson, 2015. See Appendix A). Institutional ethnography is continuing to gain traction in Canada, North America, Australia, and other European countries, as a way of exploring how institutional relations are coordinating the experiences and activities of patients and service users (Benjamin, 2011; Campbell, 2000; Diamond, 1992; Rankin, 2003), social and health workers (Campbell, 2001; de Montigny, 1995; Hamilton & Campbell, 2011; Lane, McCoy, & Ewashen, 2010; Limoges, 2010), and nurses (Campbell, 2001; McGibbon, Peter, & Gallop, 2010; Rankin & Campbell, 2006). Being different from other sociological approaches, a

researcher using IE takes the standpoint of the individuals in the local situation, with the intention of discovering, mapping and solving the puzzle of how things happen (DeVault & McCoy, 2012). This inquiry additionally provides the opportunity to critically reflect on the approach to IE within the New Zealand context.

### **Terminology of key principles and methods used**

Institutional ethnography has, and continues to develop, terms which have a specific meaning in an IE. Laura Bisailon, following the completion of her doctorate studies, produced a glossary of institutional ethnographic terms which is invaluable (Bisailon, 2012). Here I provide an introduction to some of those key terms to assist the reading of this thesis. An exploration of IE is provided in chapter three, and how it has been operationalised as a method of inquiry in chapter four.

In contemporary society, texts and text-mediated practices are central to ruling and governing people (Deveau, 2008a). A “text” is any document that has a “relatively fixed and replicable character” (DeVault & McCoy, p. 389), and may include, for example, formal policies, organisational forms, reports, and contracts; and less formal institutional texts, including those distributed through emails and other social media (Rankin, Malinsky, Tate & Elena, 2010). Translocally, “discourse” coordinates people talking, writing, reading, and watching “in particular local places at particular times” (Smith, 2005, p. 224). Texts, as used in this thesis, are carriers of institutional discourse where authoritative knowledge is used to organise people’s activities and experiences. For example, neoliberal and New Public Management discourses, which emphasise effectiveness and efficiency through the imposition of managerial regimes, are carried in texts and technologies of health service systems, including policies, patient management systems, and reporting (Corman & Melon, 2014; Rankin & Campbell, 2006).

Within the context of this research, the ruling relations coordinate the activities and experiences of the nurses and NPs in the local situation. Texts and discourses are produced

by the various government, professional, regulatory, health, and educational organisations and through institutional processes are reproduced and disseminated to people in the local situation. The individuals in the local situation engage with and enact the texts to varying extents and in doing so are connected or “hooked up” into the ruling relations (Smith, 2005, p. 41). The texts that enter into the local situation, and the power relationships between them, can be mapped and analysed (Smith, 2006a; S. M. Turner, 2006, p. 139). It is this interplay between the ruling relations and how they concert to organise our everyday activities and decisions that constitutes “social organisation” (Campbell & Gregor, 2004, p. 27).

My research is itself a text. From the very start of the thesis I am creating a written text with which the reader is engaging. My standpoint is potentially contentious, and is certainly designed to be critical, exploring how it is we have so few NPs working in primary health care and potentially leading primary health care services. The reader will engage with the text (and the many texts within the thesis) and in turn becomes connected through these texts into relations elsewhere (Smith, 2005), which in this context may be health policies, personal experiences of local health services, other readings and discourse. Smith states:

The text-reader conversation is active.... One side is fixed, predetermined, and remains unchanged by the history of its reading...; the other party takes on the text, in a sense becoming its voice – even ... its “agent” – and at the same time, responds to, interprets, and acts from it. (Smith, 2005, p. 105)

The research when written is fixed, while the reader’s reading of the text, and response to it, may change over time.

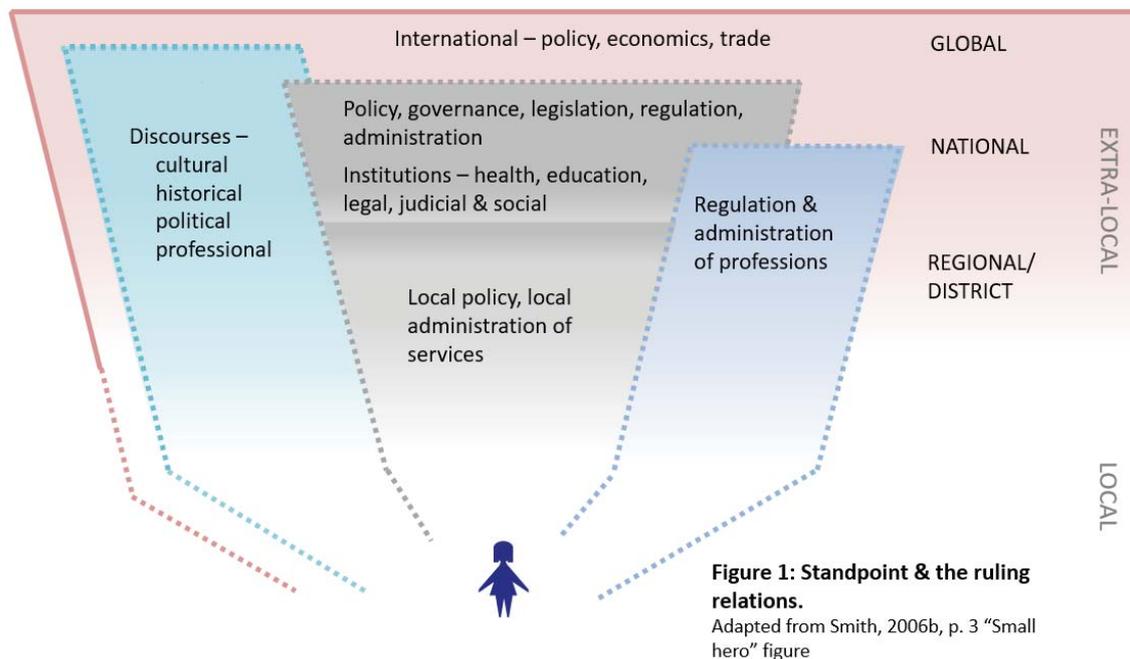
Texts are engaged with and enacted in the local setting. Those texts that have a more powerful organising effect across multiple local settings are known as “regulatory” (Smith, 2006b, p. 85), managerial, or “boss” texts (Griffith & Smith, 2014b, p. 11). The texts themselves do not have their own power or agency, it is their activation by individuals in

the local setting that gives power to particular texts and discourses, and is known as “intertextual hierarchy” (1999b, p. 66). Since the late 19<sup>th</sup> century, nursing has been shaped by various ideologies, including those that have dominated twentieth century health care, such as biomedical, pharmaceutical, technological, and managerial discourses, as well as those that have sought to challenge these discourses, for example, feminist, social justice, cultural, and health promotion discourses. Together these form a complex field of ruling relations which have coordinated the work of nurses and the development of nursing as a profession. An institutional ethnographer, then, explores how the ruling relations “both shape and are enacted through the activities” that the informants carry out in their everyday lives (Teghtsoonian, 2015).

An inquiry using IE generally begins from the “standpoint”, or lived experience, of the individual, knower, or informant, within the local setting (Smith, 2005, p. 10). Standpoint establishes a “subject position” where the ruling relations from the everyday experiences, problems or relevancies of individuals or groups can be explored (Bisaillon, 2012, p. 619). The entry to this research began initially from my standpoint of the difficulties I found in trying to become a NP in primary health care. Smith (2005) states that an inquiry begins from real issues, concerns, or problems experienced by people that are “situated in their relationships to an institutional order” (p. 32). Unlike traditional objective forms of sociological inquiry, standpoint is not viewed as bias. Rather, it is seen as a necessary aspect to the inquiry where an individual’s story and their actual experiences enable access to the discovery of the institutional processes (Smith, 2005).

Importantly, and differently from traditional sociology, it is from the standpoint of informants that we can bring those organising text-mediated activities of the institutional layers into view (McCoy, 2006). By interviewing primary informants, it is possible to explore the governing, legislative, and professional practices that are organising their experiences in the local setting (Smith, 2005). Smith depicts the ruling relations using a

“small hero” figure (see Figure 1 below) which I have adapted and refer to again later in this thesis.



Here, in Figure 1, the “small hero” is looking up and into the ruling relations from her local setting (Smith, 2006b). This figure originated from Smith’s early work on mothering (Griffith & Smith, 1987) and intended to depict how Smith’s work as a single parent was coordinated by the ruling relations. Institutional ethnography, then, offered me a way of exploring how the various institutions and organisations involved (whether directly or peripherally) coordinated, and even controlled the everyday experiences of nurses to become NPs and deliver NP services.

A variety of ethnographic methods can be used to collect data in IE, including interviewing, participant observation, and textual analysis. For my inquiry, I interviewed primary informants – NPs and NP candidates<sup>4</sup> - in order to explore the ruling relations. I was interested in the work that nurses and NPs actually had to do to become a NP and to

<sup>4</sup> A NP candidate is an experienced RN who has either completed or is near to completing a clinical Master’s in Nursing and is intending to apply to Nursing Council of New Zealand to be authorised as a NP.

implement NP services. “Mapping” is the analytical process used to explore the “day-to-day text-based work and local discourse practices that produce and shape the dynamic ongoing activities” of institutions (S. M. Turner, 2006, p. 139). Mapping begins through points of disjuncture, tension, and contradiction which are experienced in the local setting (Campbell & Gregor, 2005). Further textual analysis is undertaken to trace and reveal the texts up and into the institutional layers, with the purpose of explicating those ruling relations.

### **Introducing the primary informants**

The primary informants included NPs and NP candidates. Twelve NPs participated in individual interviews, and a further group interview was conducted on two occasions with seven and eight NPs (three of whom had also participated in individual interviews). Four interviews were conducted with NP candidates. All the participants were female, reflective of the very small numbers of male nurses working in primary health care settings in New Zealand. The NPs had been registered for between six months and eight years and all were authorised prescribers. The NP candidates had either completed their Master’s in Nursing, or were completing their final master’s paper.

The primary informants were employed by a variety of health care providers delivering health services in rural areas across New Zealand. The providers included general practice clinics, community health centres, primary health organisations, Māori health providers, and district health board funded clinics, and as such were a mixture of private, non-governmental, and publicly funded organisations. While some other staff from these organisations were also interviewed, it was the data and analysis from the NPs and NP candidates that began the process of inquiry.

## **Nurse practitioners in New Zealand: Legislative, educational and registration framework**

In this section, a description of the legislative framework, educational preparation and registration process under which NPs in New Zealand work is provided. Key texts are identified which govern and legislate the practice of NPs in New Zealand. In institutional ethnography, such texts are described as the 'regulatory' or 'boss texts' (Smith, 2006a). These texts are created and authorised by the regulatory bodies and through institutional processes instruct people on what to do, how to act, and how to carry out specific processes and practices (Bisaillon, 2012).

The first NP was registered in New Zealand in 2001 following the Ministerial Taskforce on Nursing report (1998) recommending the introduction of the NP role. This was an instrumental text in outlining the preparation of NPs, registration, and ongoing professional competency standards. The Nursing Council of New Zealand<sup>5</sup> established the requirements for the registration of the nurse practitioners, and trademarked the word *nurse practitioner*<sup>TM</sup> (Nursing Council of New Zealand, 2001). This step ensured the protection of the title prior to the enactment of the Health Practitioners Competence Assurance Act (2003). Later, and as required by the Act, the NP scope of practice was published in the government *Gazette*<sup>6</sup> (New Zealand Gazette, 2004). Development of regulatory, educational, and legislative requirements was based upon international evidence and experience, and extensive consultation in New Zealand (F Hughes & Carryer, 2002; Jacobs & Boddy, 2008; Wilkinson, 2007).

The launch of the Primary Health Care Strategy (A. King, 2001) with the introduction of PHOs, and the focus on population health and reducing health inequalities facilitated the development of primary health care nursing services. The Strategy was seen as a driver for

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<sup>5</sup> Henceforth referred to as the Nursing Council

<sup>6</sup> The New Zealand Gazette is the official newspaper of the Government and is an authoritative journal of constitutional record. It publishes notices when there is a legislative requirement to do so.

nurse practitioner development (Wilkinson, 2012). Then, in 2002, the Ministry of Health published *Nurse Practitioners in New Zealand* (F Hughes & Carryer, 2002). In the foreword, the Minister of Health, Annette King wrote that NPs were ideally placed to achieve the objectives of the Primary Health Care Strategy, which included a focus on better health for the whole population and a reduction in health inequalities between different groups. King stated, “I expect the health sector to embrace the role of nurse practitioner” (F Hughes & Carryer, 2002, p. ii). This series of texts beginning with the Ministerial Taskforce on Nursing report (1998) established the regulation, education, and legislation of NPs. In essence, these were the ‘boss’ texts governing the development of the NP workforce.

Data from the 2015 nursing workforce survey identified that 39% of then 142 NPs worked in primary health care or the community (Nursing Council of New Zealand, 2015b). 60% worked full time, and just 8% were male. 15% identified as Māori. The report estimated that there was 1 NP per 32,000 New Zealanders. The numbers of NPs registering over the past two years has increased substantially to reach 251 in August 2017.

## **Regulation**

The regulatory body for nursing is the Nursing Council of New Zealand<sup>7</sup>. Under the Health Practitioners Competence Assurance Act (2003), administered by the Ministry of Health, regulatory bodies are given the accountability and responsibility to maintain registration and ongoing competence of health professionals, ensuring practitioners are fit for practice. The overarching purpose of the Act, and therefore of the Nursing Council of New Zealand, is to protect the health and safety of the public. There are three scopes of practice defined by the Nursing Council – enrolled nurse, registered nurse, and nurse practitioner. Each scope has required competencies to be met through educational preparation, ongoing clinical practice, and professional development. The Nursing Council has a role in setting the

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<sup>7</sup> Henceforth, the term Nursing Council will be used to mean Nursing Council of New Zealand

standards, accrediting and monitoring nursing education, including for clinical master's programmes for the educational preparation of NPs.

The scope of practice statement for NPs has undergone several iterations over the past sixteen years. In 2015 the Nursing Council undertook a further consultation on the scope of practice of the NP. The scope was broadened and the requirement restricting NPs to a specific area of practice was removed (Nursing Council of New Zealand, 2015a). The Nursing Council believed that the changes would support NPs to meet future health needs of particularly rural and other underserved, diverse, and ageing populations.

The new scope of practice introduced in April 2017 is as follows:

Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practise beyond the level of a registered nurse. Nurse practitioners work autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and improve access and population health outcomes for a specific patient group or community. Nurse practitioners manage episodes of care as the lead healthcare provider in partnership with health consumers and their families/whānau. Nurse practitioners combine advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to provide patient-centred healthcare services including the diagnosis and management of health consumers with common and complex health conditions. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic and laboratory tests, prescribing medicines within their area of competence and admitting and discharging from hospital and other healthcare services/settings. As clinical leaders they work across healthcare settings and influence health service delivery and the wider profession. (Nursing Council of New Zealand, 2017c)

The key changes to this latest statement included a greater focus on population health and the work of NPs as clinical leaders. Perhaps the most contentious change was that NP

services included “the diagnosis and management of health consumers with common and *complex* health conditions [emphasis added]” (Nursing Council of New Zealand, 2017c). The inclusion of the word *complex*, as well as working *autonomously*, provides a scope of practice that enables NPs to work independently in areas with poor access to services, including rural. Nurse practitioners are registered with the Nursing Council within a particular area of practice, such as primary health care, acute adult health, child and family health.

### **Educational preparation**

Nurse practitioners are advanced practice nurses<sup>8</sup> who have been educationally prepared with a clinical master’s degree and who have worked in an area of practice for at least four years. As from July 2014, all newly registered NPs are authorised prescribers working within a defined area of practice (New Zealand Gazette, 2014)<sup>9</sup>. Within the clinical master’s programme, NPs must have passed papers in pathophysiology, pharmacology, advanced nursing assessment and diagnostics, and a clinical prescribing practicum.

Having gained a clinical master’s degree, nurses are required to complete a portfolio of evidence, and submit this together with an application to the Nursing Council for registration as a NP. Through the portfolio and assessment process the candidate is required to demonstrate advanced competencies across five themes (Nursing Council of New Zealand, 2017a):

1. Provides safe and accountable advanced practice
2. Assesses, diagnoses, plans, implements and evaluates care
3. Works in partnership with health consumers

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<sup>8</sup> Advanced practice nursing (APN) is an internationally used term to describe those nurses who have expert knowledge, complex decision-making skills and clinical competencies for extended practice. It is a term which may include NPs and nurse specialists (International Council of Nurses, 2009). The term *advanced practice nursing/nurses* is not to be confused with the term *practice nursing/nurses*, the latter referring to RNs working in general practices.

<sup>9</sup> The New Zealand Gazette, 29/5/2014, No. 56, p. 1590, Notice no. 3141, describes the prescribing legislation, scope of practice statement, and the prescribed qualification.  
<https://gazette.govt.nz/notice/id/2014-gs3141>

4. Works collaboratively with healthcare teams

5. Works to improve the quality and outcomes of healthcare.

Māori health, cultural safety, and the application of the principles of the Treaty of Waitangi<sup>10</sup> are included in the Nursing Council's standards and competencies for nursing education, practice, and research (Nursing Council of New Zealand, 2011). Nurses and NPs are expected to work with individuals, whānau, and communities using the principles of partnership, participation, and protection to improve access and health outcomes. Candidates are required to undertake an assessment by a panel that includes two NPs. Once registered, NPs, in addition to holding an annual practising certificate, are required every three years to provide evidence that they have maintained competence, and have ongoing peer review of their prescribing practice by an authorised prescriber.

## Legislation

Changes to medicines legislation provided the legal framework under which NPs could prescribe in the first decade of this century through the Medicines Amendment Act (1999). Under the Medicines (Designated Prescriber: Nurse Practitioners) Regulations (2005), NPs were classed as designated prescribers able to prescribe from a specified subset of medicines within their area of practice from schedule one of the Medicines Regulations (1984). The Medicines Amendment Act (2013), repealed the previous regulations and NPs were no longer confined to a schedule of medicines, but moved to the class of authorised prescribers along with doctors<sup>11</sup>, midwives, optometrists, dentists and veterinarians. The

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<sup>10</sup> The application of the Treaty of Waitangi, signed in 1840, between Māori chiefs and representatives of the British Crown, has been compounded by different interpretations of the English and Māori texts. Māori was solely an oral language at that time, and words such as *sovereignty* had no direct Māori translation. The Crown's representatives and the Māori chiefs in essence signed different documents, though the English version was retained as the official version.

The principles of the Treaty of Waitangi were developed by the Royal Commission on Social Policy in 1988 as partnership, participation and protection (D. Wilson & Haretuku, 2015) and have been used to inform health research, nursing education and practice, and certain health policies, such as *He Korowai Oranga: The Māori Health Policy* (A. King & Turia, 2002).

<sup>11</sup> In this thesis doctor, unless otherwise stated, means medical doctor

Ministry of Health stated that this change “recognises the safe and appropriate prescribing practice of nurse practitioners ... over the past 9 years” (Ministry of Health, 2014a).

The 2014 changes to the scope of practice followed (New Zealand Gazette, 2014). NPs now have access to prescribe from the full range of medicines in the Pharmaceutical Schedule<sup>12</sup>. Additionally, the Misuse of Drugs Amendment Regulations (2014), has allowed NPs to prescribe controlled drugs for one month or three months, depending on drug class. Previously, NPs had been restricted as designated prescribers to prescribe controlled drugs in an emergency and only for three days. Again, this legislative change brought NP prescribing in line with doctors.

The work to attend to relevant pieces of legislation replacing medical practitioner or general practitioner to include NPs, and other health professionals, has been ongoing. In 2011, Carryer et al. (2011) noted nearly 60 legislative barriers that created daily obstacles to NPs fulfilling their scope of practice. Many of these have been addressed in recent years. The most recent is the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill (2015), which is an omnibus bill to increase the range of statutory functions and services provided by health practitioners, including NPs. Reference to medical practitioners has been replaced by either health practitioners, and in some cases specifically NPs.

The amendments through the Bill (Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, 2015) change the legislation of eight Acts. I have briefly outlined these below, summarising from the Ministry of Health website (2017):

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<sup>12</sup> PHARMAC (the Pharmaceutical Management Agency) are a New Zealand Crown entity with the responsibility for managing the Pharmaceutical Schedule of approximately 2000 Government-subsidised community and hospital medicines and devices (PHARMAC, 2016).

**Accident Compensation Act 2001:** Suitably qualified health practitioners will be able to prescribe aids and appliances and participate in the preparation of the client's individual rehabilitation plans.

**Burial and Cremation Act 1964:** Nurse practitioners will be able to issue death certificates for patients in their care.

**Children, Young Persons, and Their Families Act 1989:** Health practitioners will be able to carry out medical examinations ordered by the court, or as requested by a social worker, when considering whether children or young people have been abused.

**Holidays Act 2003:** Health practitioners will be able to certify proof of sickness or injury.

**Land Transport Act 1998:** Health practitioners will be able to request blood tests from drivers, and assess and report on their fitness to drive. Other amendments enable health practitioners to take blood, handle evidential specimens, and appear in court to give evidence.

**The Medicines Act 1981:** Nurse practitioners will be able to supervise designated prescribers.

**Mental Health (Compulsory Assessment and Treatment) Act 1992:** Nurse practitioners, or RNs working in mental health are able to request an assessment for a compulsory order. The assessment, to identify if someone is mentally disordered, can be undertaken by a NP if approved by the Director of Area Mental Health Services. Health practitioners, including NPs, will be able to continue to assess and treat the person to which a compulsory order has been applied.

**Misuse of Drugs Act 1975:** Nurse practitioners and RNs working in addiction services, and pharmacist prescribers, will be able to prescribe controlled drugs for the purposes of treating addiction.

Seven of the amendment Acts will commence on 31<sup>st</sup> January 2018 and the Transport Amendment Act will commence on 8<sup>th</sup> November 2018 (Ministry of Health, 2017). These changes will enable NPs to carry out further functions previously only undertaken by doctors. These are regulatory boss texts that will have a material impact on the NP scope of definition, and their work in practice.

Through this section, I have shown the range of texts that are governing both NP practice and the process of becoming a NP. Since the inception of the first NP, various changes have been made to the framework to ensure that NPs are safe practitioners and able to work to their full scope of practice. Yet despite the meticulous and robust legislative, regulatory, and educational framework, the NP workforce has struggled to become established in rural and underserved areas in New Zealand.

## **The health care sector**

Primary health care has been central to recent health care reforms in New Zealand, due to the ongoing escalation of health care costs, and a realisation globally that focusing on acute hospital service provision is unsustainable for governments (Cumming, 2015; WHO, 2008). Additionally, there is growing acknowledgement that current health services are not only costly, but are failing to adequately address inequalities in health (Commission on Social Determinants of Health, 2008; Friedberg, Hussey, & Schneider, 2010). Health is now the second largest growing sector in New Zealand, representing 7.2% of the gross domestic product, and 9.1% of the 2.236 million working population are employed in health (Ministry of Business Innovation & Employment, 2014). With the increased emphasis on primary

health care, NPs in this sector should be 'flourishing' (Wilkinson, 2012), yet this is not the case.

In 2001, the New Zealand Labour-led government introduced its Primary Health Care Strategy (A. King, 2001) with the clear aims of strengthening the role of primary health care in order to improve access and quality of health services, addressing causes of poor health status, and reducing health inequalities. The Primary Health Care Strategy built on a major reorganisation of the health and disability sector through the New Zealand Public Health and Disability Act (2000), enabling the creation of primary health organisations (PHOs) as not-for-profit non-governmental organisations (A. King, 2001). A variety of organisations with differing models of governance formed from community health providers, including iwi<sup>13</sup>, Māori and Pacific providers, community trusts, and collectives of general practices. Capitation funding, and access to other funding streams, incentivised health providers and general practices to enrol their patients in a PHO of their choice. Funding and contracting arrangements are stipulated in an annual PHO Services Agreement with the respective DHB. The user paying a fee-for-service, however, has continued for general practice services, pharmaceuticals, and diagnostics.

The Primary Health Care Strategy facilitated novel discussions on the development of primary health care nursing services across many PHOs and was seen as a driver for NP development (Wilkinson, 2012). A general election in late 2008 returned the National Party to lead the government. Within the context of the global recession and the need for tightening spending across all government sectors, the health policy document *Better Sooner More Convenient* was implemented (Ryall, 2007). The focus turned to value for money, improved technologies, care closer to home, and smarter use of the private sector. Under the directive of the Minister of Health to reduce bureaucratic layers, the PHOs were 'rationalised' reducing their number from 81 to 31. Mergers and restructures of

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<sup>13</sup> Iwi or tribes are the largest social groupings of Māori.

governmental organisations often result in reduced productivity and increased costs for between eighteen months and two years after the change is announced (White & Dunleavy, 2010). The changing and troubled environment of the primary health care sector added to the complexity of the ruling relations in which the NP workforce was endeavouring to become established.

In April 2016, a refreshed New Zealand Health Strategy (Ministry of Health, 2016c) was launched by Jonathan Coleman, Minister of Health, signalling further major health sector changes and direction. Here I shall provide a brief overview of the health sector, and include an organisational map of the key structures relating particularly to primary health care. Nurse practitioners are employed within various organisations, including privately owned general practices, not for profit health provider organisations, such as PHOs, Māori provider organisations, and health centres, or general practice health clinics owned by district health boards (DHBs). Texts coordinating NPs' work in practice settings are created by these organisations, often beginning with policy established at government level, and enacted and adapted by organisations at district and local levels.

The Minister of Health, appointed by the Prime Minister, heads the Ministry of Health, *Manatū Hauora*. Under the New Zealand Public Health and Disability Act (2000) the Minister of Health is responsible for administering more than twenty Acts of Parliament, and steering and implementing health strategy and policy. The majority of the health system's funding comes through Vote Health from the Treasury. Funding to the twenty District Health Boards (DHBs) is allocated through the Ministry of Health using a population based funding formula that takes account of district demographics, ethnicity, high needs, and rurality. The Ministry of Health retains approximately 19% of the Vote Health funding for national services, which includes disability support services, well child, primary maternity services, certain screening programmes, and mental health services (Ministry of Health, 2016c). Postgraduate education, including for nurses undertaking a clinical

master's, is funded through Health Workforce New Zealand (HWNZ), a division of the Ministry of Health.

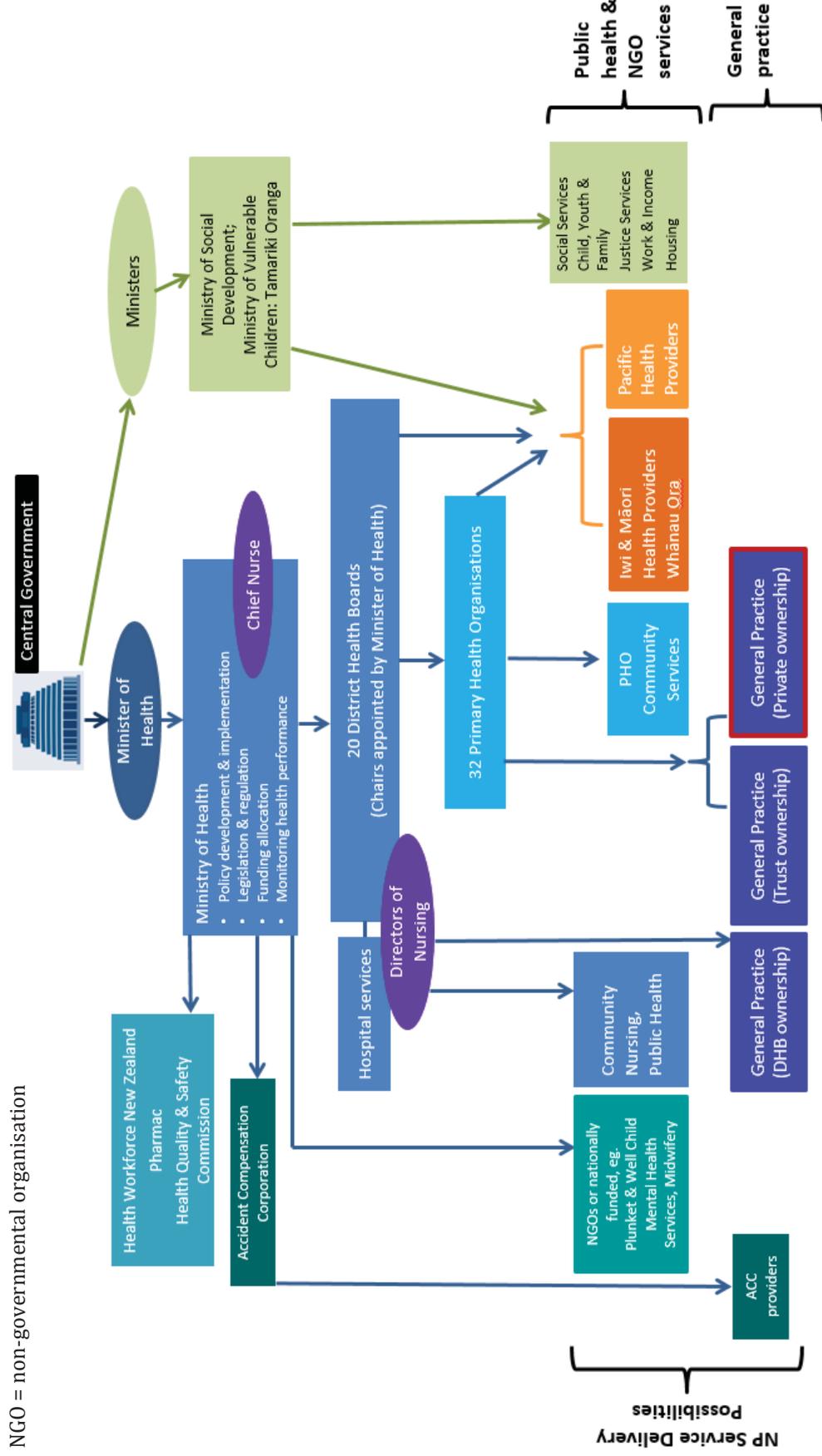
The DHBs are Crown Agents and have responsibility for the management of hospital, ambulatory, and other secondary, tertiary services, and community services. Their responsibilities in relation to primary health care are as planners and funders, in essence purchasers of primary health care services for the populations they serve. Funding is allocated and contracted by the DHBs to providers such as PHOs, pharmacists, laboratories, community trusts, and private hospitals for long term care. Both hospital and primary care services are required to report on their contracts and activities, often three monthly, and respond to health targets and performance indicators as set by the Minister of Health.

Despite the range of organisations and services providing care in the community, the model of general practitioner-led services, mostly through private general practice, remains the dominant model. The New Zealand Health Strategy (Ministry of Health, 2016c) stated that there were 12.6 million daytime visits to general practitioners per year, and 2.8 million visits to general practice nurses. Using these figures, and based upon an estimate of hundred NPs working in general practices who would see potentially 70 patients per week over 42 weeks in a year, then NPs would be contributing no more than 2% of all consults provided in a general practice. There is a great opportunity for New Zealand to better utilise the NP workforce to alleviate pressures and costs in general practice services. The diagram, on the opposite page (p. 27), depicts the key structures of the health service (extant at May, 2017) showing the connections between central government, primary health care, and primary care services, and where NPs could potentially be employed. The diagram is based upon the New Zealand Health Strategy (Ministry of Health, 2016c. See Appendix D) and simplified. I have broadly categorised services “out of hospital” as primary health care and primary care, aligning with free services, and services for which the user often pays.

**Figure 2: Simplified structure of the organisation of the primary health care sector**

The majority of general practice services are provided through general practitioner-owned private practices.

NGO = non-governmental organisation



However, there are multiple contracted services across the sector. General practices provide free immunisations as part of the National Schedule, and have various funding schemes to provide free visits for those under 13 years, and for other groups of patients considered to have high needs (health or deprivation) or long term conditions. Similarly, some Māori health providers and Pacific health providers may have a low user fee for some groups of patients.

### **Rural health workforce**

As with many other countries, the medical workforce in New Zealand is poorly distributed with few choosing to work in general practice, especially in rural areas. Globally, the medical workforce is ageing with nearly one third being over the age of 55 years (OECD, 2013). There is a growing imbalance of doctors choosing to be specialists, largely due to remuneration, and a continuing shortage of general practitioners (OECD, 2013). The Health of the Health Workforce report released in 2014 identified that general practitioners were one of New Zealand's critical workforce shortages (Ministry of Health, 2014c), with 44% planning to retire within ten years (Royal New Zealand College of General Practitioners, 2016). Over the past two decades there have been a variety of funding initiatives and schemes to increase the number of general practitioners in rural primary health care with little overall impact (Goodyear-Smith & Janes, 2007). Health Workforce New Zealand established projects to improve general practitioner training to increase recruitment into general practice, and multidisciplinary rural immersion schemes to promote rural health to health students, including nursing and medical students. Data on the success of these is not yet available. A disproportionately high amount of funding in the New Zealand health sector is spent on funding general practitioner training compared to postgraduate education for nurses (Ministry of Health, 2014e). Despite the potential of NP services, the main drive and response from policy makers and general practitioner leaders continues to be around finding ways to promote general practitioner numbers and retention rates.

## **Primary health care or primary care**

Throughout this thesis I have deliberately used the term primary health care. Since the Alma-Ata Declaration of 1978 (WHO, 1978) the intention of the concept of primary health care has been to reduce health inequalities through the provision of services that include primary prevention and screening, health promotion, generalist first-level services from a range of health providers, and public health activities to improve the health of communities. Services should be accessible, equitable, consumer-centred and participatory, being responsive to individual and population health needs (WHO, 2008). Thus primary health care can be seen as embracing both public health strategies and primary care services, the latter being more traditionally described as first-level services provided through general practices, and general practitioner-led care.

A position statement was released in 2008 by the Ministry of Health's Primary Health Care Nursing Expert Advisory Group (Sheridan, Finlayson & Jones, 2009). The statement drew on the 1840 Treaty of Waitangi being the founding document of New Zealand (Department of Health, 1992), the Alma-Ata declaration of primary health care (WHO, 1978), and the New Zealand Primary Health Care Strategy (A. King, 2001). Primary health care nurses were seen as providing a population health focus and using socially and culturally acceptable practices to increase access to care where people live and work to reduce inequity in health status particularly for Māori, Pacific and other underserved populations. Additionally, primary health care nurses "make a significant contribution" (p. 95) in building relationships in the community and across sectors to facilitate and strengthen community action to promote health and well-being.

However, the terms primary health care and primary care are often used interchangeably, but do not necessarily have the same meaning. Despite the Primary Health Care Strategy (A. King, 2001) being based upon the principles and activities laid out in the Alma-Ata

declaration, and the position statement described in the above paragraph (Sheridan et al., 2009) the current Ministry of Health's website states:

Primary health care relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening. (Ministry of Health, 2014d)

The description used by the Ministry of Health describes general practitioner-led *primary care*, as the usual model of health care delivery in New Zealand, focusing on work with individuals rather than a population based approach. Nurse practitioners are not mentioned. In many ways, the tension between the definition of primary health care, underpinned by social justice values, and primary care, delivered within a biomedical model, is at the heart of this thesis. It has been argued that NPs work within the principles of primary health care, reducing health inequalities, and so provide an alternative approach to meeting the current global health challenges as advocated by the WHO (Browne & Tarlier, 2008; Carryer & Yarwood, 2015; WHO, 2008). The term *primary health care* is then used in this thesis as it was intended in the New Zealand Primary Health Care Strategy (A. King, 2001), and the primary health care nursing position statement (Sheridan et al., 2009) and *primary care* is used when explicitly discussing general practitioner services.

## **Thesis structure**

### **Chapter one: *Introducing the study: Context and approach***

The first chapter has introduced the purpose of this study. The experiences of my own journey to endeavour to become a NP are described, and why for me undertaking the research was important. Institutional ethnography has been introduced as the approach to

my inquiry. In IE, the social world is organised and coordinated by texts emanating from the ruling relations. Texts are data, and the extent to which they are engaged within the local situation by individuals gives rise to the actions and experiences of those individuals, in this case the NPs and NP candidates. The textual material that I have included in this chapter, and in chapter two, forms part of the complex web of ruling relations.

The key texts that provide the regulatory, educational, and legislative framework for NPs in New Zealand have been described. These are the boss texts that stipulate what nurses must do to become NPs, and that govern their functions and actions as authorised, prescribing NPs. I have provided an overview of the New Zealand health sector, and identified key policies and structures to provide the context in which NPs work. Finally, I have drawn attention to the distinction between primary health care and primary care. The New Zealand framework for the development and implementation of the NP workforce is robust and safe, yet the numbers of authorised NPs in primary health care have been slow to materialise and rural populations continue to be underserved by a reducing general practitioner workforce. This is the central thesis of this research.

### **Chapter two: *Nurse practitioners: A solution for rural primary health care***

This next chapter explores the development of advanced practice nursing internationally, locating NPs within a social justice paradigm. The chapter takes the position that NPs are an effective, highly valued workforce, able to provide at least equivalent health care to general practitioners. The chapter further explores the necessity for an alternative model of health care to meet the growing health care needs of the global population, arguing that NPs are well placed to provide such care. The chapter draws on international and historical evidence.

Information is provided of the need to establish the NP workforce in rural primary health care where health inequalities persist, particularly for Māori, and where access to health services are reduced. Throughout this section, I draw on texts that support the development

of NPs as a viable health workforce in New Zealand, that to date has been under-recognised and under-valued. Nurse practitioners are in a position to work differently, attending to issues of social justice, and providing a model of care that can meet the health needs of underserved, marginalised, indigenous, and rural populations.

### **Chapter three: *Approach to inquiry: Institutional ethnography***

Institutional ethnography as an ontology and epistemology is presented in this chapter, adding to the introduction provided in chapter one. Included in chapter three is a discussion of the key epistemological reasons that led me to choose IE as the framework for this study. The organisation and coordination (even control) of the social world in which people live is text-mediated through a complex of circulating texts and discourses. I describe how text-mediated ruling is achieved, providing examples from research. Finally, I discuss the epistemological position of IE, and how knowledge of the social world begins from the standpoint of the informants and the materiality of their everyday lives.

### **Chapter four: *Methods***

Chapter four describes the methods used to undertake the study. Institutional ethnography is an iterative process where there is not clarity at the outset of the study on the exact direction, nor on the people who may be interviewed. I present a scaffold map based upon the authoritative knowledge of the process for RNs to become NPs. Included in this section is the description of the selection of informants through the research, and the interviewing process. The ethical review process is described with reference to a published article (Adams & Carryer, 2017). The methods chapter includes a description of the data analysis techniques including mapping and textual analysis.

### **Chapter five: *Working to get there: Clinical practice and education***

Chapter five is the first of three findings chapters. Data is presented from the mapping process to show the work that RNs undertake in order to become a NP, using a scaffold map

as a framework. This chapter explores features of the nurses' experiences working rurally that both supported their pathway to becoming a NP as well as illuminating the extent of particular work processes, such as to gain funding to complete a Master's in Nursing. The chapter finishes with a story of a NP candidate who over a three-year period worked to become a NP.

### **Chapter six: *The contested space of general practice***

Chapter six explores the tensions experienced by nurses and NPs in relation to claiming their space in rural primary health care. This chapter explores, through texts, the privileged position that medicine has held, and continues to hold, in primary health care. Texts are traced from local to international, exploring the institutional ruling relations that continue to organise policy, local organisations, and NPs. The chapter concludes with the recent New Zealand story of the pilot project to introduce physician assistants.

### **Chapter seven: *A fragmented system: Whose interests' are being served?***

The fragmented primary health care health sector with various models of health governance have both allowed innovation, and prevented NP development. The complexity of the sector and the competing drivers, have at times severely limited the establishment of NP services. The final findings chapter explores how the potential work of NPs is limited through particular models of care and policies, and presents a model in general practice that has worked to rewrite the texts.

### **Chapter eight: *Discoveries and implications***

The final chapter of this thesis discusses the discoveries and implications for the establishment of the NP workforce in rural health in New Zealand. The ruling relations are summarised that are governing the NP workforce. Learnings from the study are explored, and recommendations made for the future direction for research. This chapter also includes

a reflection on IE as used in this study, commenting on the value of using IE to explore social justice issues both in New Zealand and elsewhere.

## **Publications**

In the appendices (A, B & C), I include three articles published that have arisen from this study. The first introduced IE to health and nursing in New Zealand (Adams et al., 2015. see Appendix A). Through this article we explained the key terms of IE, presented research in health and nursing that we believed to be particularly applicable to the New Zealand setting, and briefly introduced my inquiry. The second article (Carryer & Adams, 2017. See Appendix B) grew from Jenny Carryer's long term commitment to the New Zealand NP project and developing a health workforce that was "fit for purpose" to meet the health inequalities and growing health needs. We used data from my study that indicated how NPs were working in ways that were different to the biomedical model of general practice. We argued that the focus of research should move away from comparing NPs to doctors in terms of equivalence, and instead explore the value-add of NPs in promoting social justice. The third article was published by SAGE in their online collection of research methods cases (Adams & Carryer, 2017. See Appendix C). This case study explored the ethics review process as encountered for this research, identifying how an IE was both problematic due to its open-ended nature, but also how exploration of the ruling relations of the ethics review process facilitated how I positively approached the process.

## Chapter Two

# Nurse Practitioners: A Solution for Rural Primary Health Care

### Introduction

Nurses have been delivering health services autonomously and at an advanced practice nursing level successfully for decades in areas of deprivation, rurality, and with indigenous and other marginalised populations (DiCenso et al., 2010; Holt et al., 2014). Internationally, NPs are now established in most health care environments (Sullivan-Marx, 2010; Towers, 2005) from highly acute and specialised areas to generic health care practice across urban and rural areas. Nurse practitioners are contemporary, appropriately educated, and skilled members of the health workforce who have the potential to address global health challenges and reduce health inequalities (WHO, 2008). Despite New Zealand developing a robust regulatory, educational, and legislative framework, with the appropriate texts to govern the enactment of the NP project, growth of the NP workforce has been slow.

The NP project in New Zealand is located within the historical trajectory of the development of the advanced practice nurse role globally. By using institutional ethnography, my concern is how texts and discourses are organising the work and activities of RNs and NPs, ultimately coordinating the establishment of the NP workforce. Literature for this chapter has been purposefully chosen beginning from my standpoint and entry to this inquiry. I make no claims that the literature presented here meets the requirement of a more conventional systematic and analytic literature review. Rather evidence is intentionally chosen that reveals and demonstrates that NPs are a solution to the current health needs and workforce issues in New Zealand.

Using IE enables both the understanding of how texts have the capacity to rule, but also how we can begin to use texts to redress dominant modes of governing and ruling. Corman and Melon (2014) describe how we “can begin to discover ways to insert texts and discourses that activate the interests” (p. 171) of those in the local situation. Texts, historically and through to the present, continue to sustain the efforts and actions of various individuals and organisations to implement NP services. At times, I also consider those competing texts and discourses that have historically created tensions and obstacles that persist today. This chapter then explores the textual context for the development of the NP workforce in New Zealand.

There are three main sections to this chapter. In the first section, research is reviewed that identifies NPs as a safe, effective workforce. This substantial body of research has provided the rationale required to develop health policy to establish NP services. Indeed, there is a growing body of evidence that NPs provide superior care across a number of parameters when compared to doctors. However, the persistence to produce research that is so-called ‘equivalent’ when comparing to medical practitioners poses a risk to exploring and promoting the value-add of NP services (Carrier & Adams, 2017).

Secondly, I draw on literature that explores the development of advanced practice nursing internationally, locating NPs within a social justice paradigm. Achievements, challenges faced, and ongoing discourses are described that remain pertinent to the current environment for NP development in New Zealand. Advanced practice nurses have been providing care (and cure) to underserved, marginalised, rural, and indigenous populations for well over a century both overseas and in New Zealand, and in fact before the advent and domination of modern medicine (Group & Roberts, 2001). Internationally, there is a call for nurses and NPs to work to reduce health inequalities and promote social justice (Browne & Tarlier, 2008; B. L. Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014;

Kooienga & Carryer, 2015; Meleis & Glickman, 2014). These texts have powerfully organised the profession of nursing to promote the work of NPs (Carryer & Yarwood, 2015).

Thirdly, the current international NP situation is explored. There is no internationally agreed definition for NPs, and scopes of practice vary between countries and between states and provinces in the United States (US), Canada, and Australia. Documents and policies show that the New Zealand NP project has drawn on international documents and experiences to achieve a coherent and essentially a best practice model for educational preparation and scope of practice. In rural and underserved areas, data is provided to show how NPs are increasingly becoming the dominant providers of primary health care.

In the final section I return to New Zealand presenting data on the population, rurality and health inequalities. Health inequalities between Māori, the indigenous people, and the predominant white population of European origin, known as Pākehā<sup>14</sup>, have been widely described as being unacceptably high (Blakely, Tobias, Atkinson, Yeh, & Huang, 2007), as are a range of other socio-economic indicators, including poverty, housing, educational achievement, and employment (Ministry of Health, 2015c). The rural population in New Zealand is predominantly Pākehā or Māori, and discussion through this section is largely kept to these two groups. The discourse of reducing health inequalities in New Zealand is persistently used. Nurse practitioners are ideally placed to work in rural areas of New Zealand, promoting social justice and providing comprehensive health services to those

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<sup>14</sup> The definition of *Pākehā* has developed over time. Prior to the arrival of European settlers Māori did not have a name for themselves as a whole, instead naming their tribal groups. The word *Māori* during the early 19<sup>th</sup> century derived from *tangata Māori* which meant 'ordinary' or the 'usual' people (M. King, 1985). Pākehā at that time meant white person. Early European/white settlers were predominantly from Britain, and increasingly over the years from other European countries, and more latterly from South Africa and Zimbabwe. Today, Pākehā is often used to mean people of non-Māori, non-Polynesian and latterly, non-Asian descent. The term is particularly useful when describing culture, and within the bicultural model of New Zealand Pākehā culture can then be defined differently from Māori culture (M. King, 1985). Pākehā is a term in general use throughout New Zealand research and literature, and like Māori is a collective noun.

underserved and marginalised groups, as they have done historically, and do so successfully overseas.

## **Nurse practitioners: A safe and competent provider**

My study is predicated on the evidence that NPs are a highly competent and cost-effective workforce who use advanced clinical and decision-making skills to examine, diagnose, and prescribe in a way that, until recently, was solely under the jurisdiction of medical practitioners (J. C. Bauer, 2010; Fisher, 2010; Group & Roberts, 2001; Pirret, Neville, & La Grow, 2015). Over the past two decades a body of research has been analysed and presented in systematic reviews comparing care provided by NPs and doctors demonstrating, at the very least, equivalence (Dierick-van Daele, Metsemakers, Derckx, Spreeuwenberg, & Vrijhoef, 2009; Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2005; Martínez-González et al., 2014; Mundinger et al., 2000; Newhouse et al., 2011; Swan et al., 2015). Some examples of key research are presented below, including utilisation of NPs, process of care, patient outcomes, and cost effectiveness.

In relation to consultation types, a retrospective cross-sectional analysis compared NPs, physician assistants (PAs), and physicians for primary care encounters with patients who were part of the Veterans Health Administration in the US (P. A. Morgan, Abbott, McNeil, & Fisher, 2012). In 2010, 10.6 million primary care encounters with patients took place and were analysed. Of those encounters, 19.2% were with NPs. Nurse practitioners, physician assistants (PAs), and physicians were found to fill similar roles. While the patient complexity score was slightly higher for physicians, the researchers noted that these differences were small. Additionally, physicians saw equal numbers of less complex patients. Importantly for the development of the NP workforce, they concluded that this “challenges the prevailing notion that NPs and PAs see patients who are less medically complex than those cared for by physicians” (P. A. Morgan et al., 2012, p. 4).

Research comparing the work of NPs to doctors or physicians has been ongoing for several decades. Particularly notable was a randomised controlled trial (RCT) conducted between 1996 and 1997 on 3397 adults in primary care settings assigned to either NP or physician care, which found patient outcomes were comparable (Mundinger et al., 2000). A two year follow up on 406 of those patients again found no difference in health status or use of specialist or hospital usage (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004). Since then, various systematic reviews have been conducted. Newhouse et al. (2011) reviewed studies undertaken between 1990 and 2008 comparing advanced practice nursing care to care provided by physicians. Specifically, for NPs a total of 37 studies (fourteen RCT trials and 23 observational studies) were reviewed that examined patient outcomes. Overall, a high level of evidence was found that demonstrated NPs provide at least equivalent care to physicians.

With regard to prescribing, a systematic review of 35 studies compared nurse and physician prescribing and found that nurses prescribe in similar ways to physicians in relation to patients, their diagnosis, medication types, and dose (Gielen, Dekker, Francke, Mistiaen, & Kroezen, 2014). In terms of clinical outcomes, only tentative conclusions could be drawn due to the low methodological quality of the study designs. However, taking this into consideration, clinical outcomes were the same or better for NPs. Perceived quality of care was similar or better for nurses compared to physicians, and patients treated by nurses were just as satisfied or more satisfied. The argument sometimes made that NPs prescribe more medications than doctors was not demonstrated in the review.

With the increase in number of NPs, particularly in the US, studies with large numbers and increasing statistical power are being conducted. A recently published retrospective cohort study in the US of 345,819 older adults with diabetes receiving Medicare, compared the care provided by NPs with primary care physicians (Kuo et al., 2015). The researchers found that care from a NP was associated with a lower risk of hospitalisation for conditions that could

be defined as preventable. They concluded that primary care provided by NPs was at the very least comparable to that provided by general physicians.

The ongoing evidence of the equivalence of NP practice led Alison Pirret, in her doctoral research, to compare the diagnostic reasoning abilities of thirty NPs and sixteen doctors relating to a complex case (Pirret et al., 2015). Nurse practitioners and doctors, who were completing postgraduate specialist training, were given a complex case scenario with a 'think aloud' protocol that was used to assess their diagnostic reasoning abilities through a panel of experts. The study found that there was no statistical difference in NPs' ability to generate diagnoses, and formulate and implement an action plan. While this study is small, it indicates the ability of NPs to work with high levels of health and medical complexity.

While equivalence has been thoroughly substantiated, evaluating the cost-effectiveness of NPs is more problematic. Many studies focus on the comparisons of consultation time, basic salary costings, ordering of diagnostic tests, and follow-up and referrals. However, a thorough analysis of cost-effectiveness requires much more than this. Martin-Misener et al. (2015) undertook a systematic review of the cost-effectiveness of NPs in primary health care settings. They found there was high quality evidence to conclude that NPs provided care that was cost-effective with patient outcomes demonstrated to be at least equivalent to, or better than care provided by doctors. However, the researchers raised the need to overcome the methodological and ethical challenges for assessing cost across a whole range of parameters. Such parameters include professional expenses, overhead costs of private businesses, salary, and the long-term outcomes relating to morbidity and mortality. Such a system wide evaluation would provide clarity to health service planners challenged by rising health care costs, chronic disease, and health inequalities.

Thus the literature reveals that NPs are providing care that, across some parameters, is superior to the care provided by doctors. Martínez-González et al. (2014) undertook a systematic review comparing nurse-led care, including NPs, to care provided by physicians

in community, general practice, and ambulatory care settings. Twenty-four randomised controlled trials with over 38,000 participants were included in the review. With a caution regarding methodological limitations, they stated:

Our review suggested that nurse-led care is associated with higher patient satisfaction, lowered overall mortality and lowered hospital admissions.... The effect of nurse-led care on hospital admissions and mortality was particularly present in studies of ongoing care and non-urgent visits and when NPs ... provided the care. [The] surprising and important finding, especially that nurse-led care could lead to reduced mortality, should be addressed in future studies. (Martínez-González et al., 2014, p. 14)

Similarly, in a smaller systematic review, researchers again concluded that advanced practice nurses, including NPs, provided safe and effective primary care, that for some measures was superior to physician-led care (Swan et al., 2015). Further, these researchers identified that advanced practice nurses in these studies provided care that was “in some ways different” (p. 403) from the care provided by physicians. This will come as no surprise to NPs who work within a model of care where the individual patient’s needs are considered within the context of family, community and environment.

The high patient satisfaction scores found throughout research on NPs, are likely a reflection of the use of a nursing model and approach to care that particularly focuses on communication strategies, advocacy and health promotion (Budzi, Lurie, Singh, & Hooker, 2010; Ploeg et al., 2013). While this ‘other’ work has been described qualitatively (for example, Tarlier & Browne, 2011), mostly NP work is described through case studies, such as Bourgeois et al. (2014a) or commentary in nursing or NP journals. It has always been a challenge for the nursing profession to clearly define what nurses do outside of the dominant biomedical discourse. The same issue persists for NPs, and leads to ongoing misconceptions from the medical profession as to what NPs do, and how their work is complementary to, a ‘value-add’, or even more appropriate than the work of doctors.

The ongoing drive to produce and deliver research which directly compares the work of NPs and doctors, renders invisible the 'other' work that NPs do. Hughes and colleagues (F. Hughes, Clarke, Sampson, Fairman, & Sullivan-Marx, 2010) referred to this as defensive research designed to demonstrate safety within the dominant paradigm of medicine. Further, NPs are being subsumed into the prevailing discourse of new public sector managerialism, where the focus is on health outputs and outcomes (Aranda & Jones, 2008). Aranda and Jones argue that such dominant discourses, prevalent in the ruling relations, leave NPs in a position of feeling both ambivalent and subordinated. It is perhaps not surprising that research which extols the models, qualities, and characteristics of the 'other' work of NPs, which would enhance health care provision, is limited.

While research to demonstrate comparative work and safety was a necessity earlier in the development of the NP workforce, there is a call to shift research to identify what constitutes optimal care (F. Hughes et al., 2010). There are increasing data that NPs are providing superior care across some parameters of primary health care work when compared to doctors. Carryer and Adams (2017) argued in a recent paper that having conclusively established equivalence with doctors, research now needs to focus on the value-add of NPs in primary health care (Carryer & Adams, 2017, see Appendix B):

In this paper we argue that nurse practitioners (NPs) offer the exact transformation in care that the WHO seeks. We challenge the necessity of continuing to conduct research demonstrating direct comparisons of equivalence between nurse practitioner (NP) and doctor or physician-led care, and in fact argue, using our data, that such questioning has limited the way in which NP services could be envisaged, and limited acknowledgement of their potential points of difference. (p. 2)

Nurse practitioners are the ideal workforce to provide health services to such communities, working from within a social justice framework.

## **Social justice: The development of advanced practice nursing**

Nurse practitioners work within a philosophy of nursing, embracing the principles of primary health care to promote health and wellbeing, and reduce health inequalities for individuals, whānau<sup>15</sup> and communities (Carryer & Yarwood, 2015). This study takes the position that NPs are a solution to meeting health care needs and reducing health inequalities (Browne & Tarlier, 2008; Carryer & Adams, 2017; Carryer & Yarwood, 2015; Wilkinson, 2012). Essential to achieving health equity is social justice (Commission on Social Determinants of Health, 2008; Marmot & Bell, 2012). Browne and Tarlier (2008), from their work in rural Canada, advocated for NPs to develop their role from a critical social justice perspective, stating that it is this aspect which particularly demonstrates the “value added component of NP practice” (p. 89). Historical texts are presented in this section that have facilitated the establishment of the NP workforce in rural primary health care internationally and in New Zealand. Such texts have created a professional nursing discourse that NPs provide health services that meet the health needs of communities and reduce health inequalities.

### **Social justice and nursing**

Social justice has been a central discourse in nursing, particularly in primary health care and rural health (Browne & Tarlier, 2008). Nursing leaders and activists since the mid 1800s, such as Florence Nightingale, Lilian Wald, Lavinia Dock, Margaret Sanger and Mary Breckinridge, embraced their civic responsibilities with social justice being the driver to improve the health of the socially disadvantaged (Riley & Beal, 2010; J. L. Thompson, 2014; Tyer-Viola et al., 2009). While nurses’ knowledge in those early days was tacit and empirical, there is now an abundance of indisputable global evidence of the ongoing

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<sup>15</sup> Whānau is a concept derived from the oral Māori language. The term now has common usage in the English language in New Zealand, including in legislation and policy. There is no direct translation of whānau. The term encompasses an extended family group who have common ancestors connected through their tribes and sub-tribes. Additionally, individuals who have established a special relationship can become whānau (Walker & Ngati Porou, 2006).

existence of health inequalities that persist both between and within countries as a result of social injustices (Commission on Social Determinants of Health, 2008; WHO, 2008). Nurse practitioners are ideally placed to increasingly contribute to tackling social injustices, reduce health inequalities, and improve health and well-being.

Social justice is an ethical concept which implies fairness and equity in relation to human rights and to the benefits of society (Kelley, Connor, Kun, & Salmon, 2008; Reimer Kirkham & Browne, 2006). The ideal of social justice draws attention to inequities of power relations, poverty, vulnerability, racialisation, colonisation and marginalisation (Reimer Kirkham, Van Hofwegen, & Harwood, 2005; J. L. Thompson, 2014). Despite the lack of a coherent definition in nursing literature on social justice (Boutain, 2016), nursing scholars are calling for a move for nursing to apply a social justice agenda to achieve political, economic and social transformations (Anderson et al., 2009; Boutain, 2016; Yanicki, Kushner, & Reutter, 2015).

Further, social justice is seen as both a professional and civic or social responsibility of nurses (Boutain, 2016; Kelley et al., 2008; Tyer-Viola et al., 2009) and that morally and ethically nursing work should be located within a social justice framework to promote equity in health (Anderson et al., 2009; Yanicki et al., 2015). The International Council of Nurses *Code of Ethics* states:

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services. (International Council of Nurses, 2012, p. 2)

However, nurses are often the predominant health workforce in rural and community settings, and particularly in communities with vulnerable, indigenous, and marginalised populations, where they have the awareness and opportunity to redress issues of social

injustice (Tyer-Viola et al., 2009). This international knowledge was one of the key principles utilised by New Zealand in the development of the NP role within a population health focus:

Nurse practitioners work towards health gain to address and reduce inequalities and inequities in health... [and] should continue to evolve in response to changing societal and health care needs. (F Hughes & Carryer, 2002, p. 3)

These principles were translated into competencies that NPs are required to demonstrate in their application to apply for registration as a NP in New Zealand, including to improve access and equity of health outcomes (Nursing Council of New Zealand, 2017a). More recent and powerful global documents, such as the Institute of Medicine (2011) report on the future of nursing, and the All-Party Parliamentary Group on Global Health (2016), have strongly presented the argument for developing the nursing workforce to improve health outcomes.

### **History of advanced practice nursing**

The NP role itself originated during the mid 1960s in the US in order to increase access to health care for children following the uneven distribution and shortage of physicians (Silver, Ford, & Day, 1968). However, prior to this there are accounts where nurses and midwives were working across the care and cure divide, administering to sick and promoting the wellbeing of their communities (Keeling, 2007; Lundy, 2014). The dark period of nursing is described as being from the 1600s to 1850 (Dock & Stewart, 1932; Lundy, 2014). During this time, the autonomy of nursing work in Europe and North America was frequently challenged by the religious or political systems of the time, and nurses were often without education and reduced to a life of servitude (Dock & Stewart, 1932; Ehrenreich & English, 1972; Group & Roberts, 2001; Lundy, 2014). Despite the overarching stigma and sense of menial work associated with nursing, there were still examples where nurses broke from, usually religious orders, to develop innovative services to meet the

needs particularly of the poor and frail (Nelson, 2001; Wolf, 2006). Overall, the dark period set back the development of nursing significantly with connotations from this time continuing to be evident through the twentieth century.

The mid to late 19<sup>th</sup> century saw the advent of the 'modern' nurse, heralded by Florence Nightingale, and the beginnings of nursing as a profession. Nightingale was a reformer of health care, nursing, and even the British Army from an insider position (Hektor, 1994). In today's language we might describe Nightingale as an advanced practice nurse who used contemporary interdisciplinary knowledge to empirically develop best practice and educate nurses. Yet Nightingale's popular legacy of nurses as women devoted to caring for the public, unquestioning and subservient to medical and administrative authority (Roberts & Group, 1995) was contradictory to the women's movement. Feminists were fighting for the rights of women, including suffrage, employment status, and societal position (Hektor, 1994). Hektor's feminist critique of Nightingale argued that her vision was still obscuring the contemporary view of the future of nursing, and that nursing, as has happened time and time again, had been sold out to male politicians and medical men.

From the late 1800s to early 1900s, both nursing and medicine worked to define educational preparation, qualifications, regulation and scopes of practice for their professions. The key consequences of this for nursing were a more limited scope of practice for nurses, a shift from community to hospital doctor-led care, and nurse training becoming established as hospital based, often delivered by doctors (Jacobs, 2005). Andrist (2006) argues that training nurses in hospitals was "perhaps the most critical mistake for the future of the [nursing] profession" (p. 9). Not only was the advanced work of nurses in the community marginalised, but nursing positioned itself as being under the control and authority of doctors and hospital authorities.

Additionally, the period of change in nursing at the turn of the twentieth century formalised the gendered division of labour between care and cure. Nurses (women) performed healing

roles, and doctors (men) focused on the scientific approach to medicine of objectively assessing signs and symptoms, diagnosing and treating (Jecker & Self, 1991). It is argued that the medical monopoly of health and the hegemony of medicine that became so resolutely established through the last century still remains (Group & Roberts, 2001). These historical discourses have perpetuated, and today are considered to be one of the key challenges to the development of NPs (Hain & Fleck, 2014; Kleinpell et al., 2014; Naylor & Kurtzman, 2010; Poghosyan, Nannini, & Clarke, 2013).

### **Advanced nursing work, social justice, and rural health**

For more than a century, nursing has been concerned with social reform and its social justice or civic responsibilities to local communities (Nelson, 2001). While nursing and feminism have often had an uneasy alliance (Andrist, 2006; Hektor, 1994), the NP movement has been supported and further motivated by the women's and civil rights movements (Fairman, 2010; Geary, 1995; Wolf, 2006). Historically, nurses have worked to both achieve social reform, and provide advanced nursing services to victims of war, women and children, marginalised and under-privileged groups, and those in rural communities (Andrist, 2006; Keeling, 2007; Roberts & Group, 1995). The strong sense of social justice today is continuing to drive leaders of NP development in primary health care and rural settings.

Yet the challenges faced and barriers experienced by those advanced nurses in the past are echoed in those being faced today (Wood, 2010). Wood argues that viewing current professional issues faced by rural nurses through a historical lens offers fresh insights for nurses now, enabling greater understanding of their current context. In essence, Wood is describing the necessity of explicating the texts within a historical trajectory, a method used in IE to locate historically how things happen in the social world. Further, I would argue the texts showing the rich heritage of advanced nurses working within a social justice context

demonstrate that NPs have both a historical claim to rural healthcare work, and the competencies with which to do this.

Throughout history, there are examples of feminist nurse leaders and advanced nurses who have worked to improve health equity and often to achieve social reform. For example, Lillian Wald founded the Henry Street Settlement, considered the “birthplace of public health nursing” in the US (Keller, 2011, p. Foreword). This was established as a nurse-led service for poverty stricken immigrants in New York City in 1893 (Keeling, 2007), and initiated a nationwide rural nursing service which commenced in 1912 (Bushy, 2000). Today, the Henry Street Consortium is a group of tertiary education institutions in the US teaching and researching public health nursing<sup>16</sup> focusing on population health interventions (Schaffer, Schoon & Brueshoff, 2017). Mary Breckinridge provided midwifery, public health nursing and district nursing services to the largely indigenous rural and deprived population of Appalachia (E. West, 2013). In the examples of both Wald and Breckinridge, nurses worked at an advanced level for their time, treating and prescribing for common health conditions and emergencies (Keeling, 2007; E. West, 2013). There was also acknowledgement of the need for what we would call today call in New Zealand culturally safe practice<sup>17</sup>. However, increased regulation of nursing practice, and challenges from the medical profession led to the reduced scope of nurses working in these settings (Keeling, 2007; E. West, 2013). Interestingly, at a local level in Appalachia, nurses and rural physicians responded “to this assault on autonomy” (E. West, 2013, p. 221) to create one of the first family NP certificates.

In rural Canada in the early part of the last century, rural populations were served predominantly by nurses with generally no access to medical care (Jackman, Myrick, & Yonge, 2010; Ross-Kerr, 1998). In Alberta, a rural district nursing service was established

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<sup>16</sup> The definition of public health nursing practice (Schoon, 2011) is aligned with the New Zealand position statement on primary health care nursing (Sheridan et al., 2009) described in chapter one.

<sup>17</sup> The concept of “cultural safety” or *kawa whakaruruhau*, was developed by Irihapeti Ramsden (1990) in response to ongoing poor health care experienced by Māori. Culturally safe practice requires the shift of power from nurses to those receiving the care whereby they can define what culturally safe practice means for them in their lived experience (Papps, 2015).

in 1919 in areas with no hospital provision. Nurses were considered qualified to assess, treat, and manage all cases of illness, emergencies and midwifery (Ross-Kerr, 1998). Ross-Kerr likens these nurses to NPs of today. However, it has been argued that the shift from community to acute hospital-based medical care, again with increasing regulation of nursing scopes of practice, consequently led to the marginalisation of the rural nursing workforce with diminished acknowledgement of the work that rural nurses do (Jackman et al., 2010). Browne and Tarlier (2008) described how outpost nurses in Canada operated (and continue to operate today) in an expanded scope of practice comparable to NPs.

A similar story occurred in Australia, following the development of the 'bush' or district nursing service in New South Wales in 1911. Bush nurses were issued with pamphlets from the New South Wales Bush Nurses Association to enable them to treat common health problems such as coughs, colds, diarrhoea, vomiting, foreign bodies in ears and eyes, small cuts, bruises, skin infections and rashes. Additionally, the pamphlet "contained instructions for what types of drugs could be given" (Russell & Cornell, 2012, p. 72), and when the bush nurse should refer on to the doctor. In New Zealand, these would now be called standing orders, issued by an authorised prescriber. As early as 1919, bush nurses were permitted to issue sick certificates to workers. As happened elsewhere, the scope of practice of the rural nurses challenged the authority and autonomy of doctors, and this had a lasting legacy on the development of advanced practice nursing.

### **Advanced practice nursing in rural New Zealand**

The historical development of professional nursing within New Zealand should be contextualised within the impact of colonisation both on the indigenous Māori people and on the marginalisation and exclusion of Māori women from nursing (McKillop, Sheridan, & Rowe, 2013). Prior to the colonisation of New Zealand, healing specialists, known as *tohunga rongoā*, diagnosed and treated symptoms within their Māori communities (Best, 1934). The arrival of the Europeans in the nineteenth century resulted in the dispossession

of land and resources, land wars, poverty, and the spread of infectious diseases (Tuhiwai Smith, 2012). The Māori population fell by an estimated 75% to 46,000 due to war and infectious diseases, while the Pākehā population rose from 2000 to 770,000 (Statistics New Zealand, 2015c; Orange, 2012; Tuhiwai Smith, 2012). Colonisation practices through the late nineteenth century included the introduction of westernised hospital-based models of health care that further disenfranchised Māori (McKillop et al., 2013; Richardson, 2004).

Early attempts to train Māori nurses to help tackle European-induced health problems through the introduction of the Māori Health Nursing Scheme in 1899 was a failure, due to the lack of resourcing and support from local hospital boards, and was disbanded in 1910 (McKillop et al., 2013). The Native Health Nursing Scheme, which ran between 1911-1920, had no more than twenty nurses working with mostly rural Māori communities at any one time, and throughout this period, only three Māori RNs were employed. Descriptions in historical documents showed how the RNs were required to work beyond their level of training to manage serious illness, including infectious diseases, and accidents (McKillop et al., 2013). The focus of these schemes was on improving access to health care and health equity through nursing services, though without the application of cultural safety.

Backblock nursing services were introduced in 1909 by the New Zealand government (Wood, 2009). The Nurses Registration Act 1901 had introduced a three year standardised hospital training. While some charitable district nursing services already existed, a national service for remote districts was required for both settlers and the Māori population (Maclean, 1932). Wood described the context:

The [backblock] scheme offered the chance for independent practice and greater responsibility... The sole nurse assigned to a district travelled over difficult, rugged terrain to settlers' tents, bush huts and small homesteads, even lighthouses, to care for the sick and injured and attend women during childbirth. The nearest physician was often 50 miles away. The nurses worked with few resources in harsh conditions and with little professional

support. They demonstrated the ingenuity, adaptability and resilience the work demanded. (Wood, 2009, p. 112)

Such RNs again showed the requirement of their work to go beyond their scope of practice and knowledge gained through their primarily hospital-based training.

Barbara Ancott-Johnson, a public health/district nurse who worked in the Hokianga, in the north of New Zealand, described that she needed to be qualified with general nursing, maternity, and Plunket<sup>18</sup> registration (Ancott-Johnson, 1973). Additionally, she had worked as a theatre sister which proved useful when she needed, for example, to extract teeth. She described a conversation with Dr George Smith, who was in charge of the area, and with whom she worked:

He said, "What are your views of a nurse making diagnoses?"

"I think it's out of my province, unprofessional and unethical."

He laughed. "Don't be such a hidebound prig. The first diagnostician in any home is Granny; then comes Mother; why else would they send for a doctor? I expect my nurses to work as a team."

"And if I have my own thoughts on any matter?"

"Of course you will have, and you're not to hold them back. You're to disagree with me if you think I'm wrong. It's only if you do that I can follow your reasoning and save the patient unnecessary pain. Also, save myself a lot of time." Ancott-Johnson, 1973, p. 25-26)

Ancott-Johnson found him to be true to his word. Her work included maternity and child care, visiting schools, providing education and treatments, attending to illness and accidents, providing nursing care at homes, immunisations, and a range of community services. Through the above conversation with the doctor, and various stories through her

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<sup>18</sup> Plunket is a not-for-profit non-governmental organisation founded in 1907 to support mothers and reduce childhood morbidity and mortality. Plunket nurses are RNs who have completed a specific postgraduate certificate. Plunket are contracted by the Ministry of Health to deliver well-child services across New Zealand for children under five years old.

memoirs, she is describing how she worked at an advanced practice nursing level, delivering care that would now be within the NP scope of practice.

While there are areas in New Zealand where the work of nurses continued to optimise their scope of practice, more medical practices were established through the mid twentieth century. Due to the increasing workload of general practitioners, particularly in rural areas, the government introduced the Practice Nurse Subsidy scheme in 1970. The aim of the scheme was to provide doctors with funding to employ practice nurses to undertake some of the routine tasks undertaken by the general practitioners. Rather than this being taken as an opportunity to utilise the knowledge and skills of nurses to promote health and prevent illness, the role of the practice nurse was limited to minor medical and administrative duties (Henty & Dickinson, 2007; Wilkinson, 2007). Interestingly, this was a retrograde step for the advancement of nursing in rural areas to improve health equity, and instead increased the dominance of the biomedical model, in essence servicing the doctor and the practice, rather than the patients and their communities.

Rural nursing across Canada, the US, Australia, and New Zealand has been described as different in its nature and scope from the practice of nursing in urban areas, and is its own specialty (Hegney, Francis, & Mills, 2014; Jones & Ross, 2003; Scharff, 2013). In New Zealand, Jean Ross<sup>19</sup>, a significant nurse leader in the development of the rural nursing workforce in New Zealand, implemented a rural nurse specialist education programme in the South Island, as part of a clinically focused master's in the early 2000s. Ross stated that rural nurses are pioneers of advancing nursing practice, having a distinctive set of rural nurse competencies (Jones & Ross, 2003; Ross, 2008). Nurses were employed as rural nurse specialists, though this term is acknowledged as being paradoxical, given that rural nurses

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<sup>19</sup> Jean Ross was a rural nurse, and between 1994 and 2003 was a co-director of the National Centre for Rural Health. She is now a lecturer at Otago Polytechnic. In 2008, she received the Rural General Practice Network Peter Snow Memorial Award in recognition of her national contribution to rural health care. In 2008 she produced and edited a book *Rural nursing: Aspects of practice* (Ross, 2008).

are generalists, requiring a broad range of nursing skills across the lifespan, often with their work overlapping with other disciplines (Jones & Ross, 2003; Long & Weinert, 2013).

Nurses in rural communities, both in New Zealand and elsewhere, have traditionally taken on advanced and extended roles, due to the lack of medical practitioners, general practice services, and access to secondary hospital level services (Jones & Ross, 2003; Long & Weinert, 2013). For example, a rural nurse specialist role was advertised for Stewart Island in 2017, in the far south of New Zealand, one hour by ferry from the mainland, or twenty minutes by plane. The island has a permanent population of 400, and 30,000 visitors per year. The role included antenatal and postnatal care, vaccinations, palliative care, district nursing, and responding to accidents and medical emergencies. There is no medical practitioner on the island, although telemedicine is now utilised. The extent of the isolation of nurses from other health services and medical practitioner support governs their level of independence and advanced practice.

Nurses live and work in their rural communities. They are often very well known by their communities, as are their families (Hegney et al., 2014; Howie, 2008a). Their children may go to the local school, their family may own a business or a farm in the local community, and they are frequently involved in local clubs and community projects (Ross, 1999). Howie described this as being akin to living and working in a “goldfish bowl of small, sometimes isolated communities” (p.45). Further, nurses in such communities are often informally on-call for local emergencies (R. Thompson, 2008), and are likely to be consulted in public places. Anecdotal evidence indicates that the recruitment of nurses to rural areas is reliant upon family and lifestyle reasons (Health Workforce Information Programme, 2009).

Over the past ten to fifteen years, nurses working in general practices (with general practitioners) have been increasingly extending and advancing their practice. The Primary Health Care Strategy (A. King, 2001), through which the PHOs were created, led to health funding and nationally set health targets to improve health screening and long term

conditions management. During this time PHOs have provided additional training, and national funding and scholarships have supported many more nurses to undertake post graduate education, including in rural nurse education, disease state management, and primary health care. It is anticipated that the need for rural health services and rural nursing will grow. The HWNZ report on rural nursing stated that “while the population in rural areas will only grow by 8.6% by 2026, the demand for rural nurses will grow by 37.1% in the same period” (Health Workforce Information Programme, 2009, p. 3).

The literature presented in this section locates the development of the NP workforce within a global and New Zealand context of social justice with a focus on achieving health equity. Nurses have been providing health services to underserved and rural populations for many years, blurring the boundary of medicine and nursing. The historical evidence identifies how nurses have been working, particularly in rural areas, in an advanced scope of practice, including diagnosing and prescribing, that would now be defined as a NP. Historically, rural nurses in New Zealand have delivered advanced health care across the lifespan. However, despite the advent of the NP role in New Zealand, the establishment of a rural NP workforce has not been realised (Carryer et al., 2011).

## **Current international nurse practitioner workforce and practice**

The Nursing Council, professional nursing organisations, policy makers, and nurse leaders in New Zealand engaged with, adapted, and enacted texts from overseas to develop the NP framework of regulation, education, and legislation in New Zealand (F Hughes & Carryer, 2002). Evidence and documents, as well as discussions with nurse leaders from overseas, resulted in a discourse of NP professional practice for New Zealand. Through these actions, individuals in New Zealand were connected with others through the institutional global ruling relations of NPs. Nurse practitioners, nurse leaders, and researchers from New Zealand are continuing to work internationally with their colleagues, engaging with, and

creating policies and documents, to support NP development across the world. This section explores the status of the current international NP workforce.

Since the first NP education programme developed in the US in the 1960s, the numbers of NPs have grown to the extent that they are approaching the “tipping point” (Buerhaus, 2010). They provide far-ranging solutions to many health care issues and, if the current trajectory continues, should be significant providers of health care in the near future (Auerbach, 2012; Buerhaus, 2010; Stewart, 2016). Other countries have followed suit, although standards of educational preparation, regulation, and practice vary enormously.

Nurse practitioners are now significant providers of primary health care in the US and Canada, particularly in rural populations which have limited access to medical practitioners. They are seen as a necessary and positive solution to the shortage of medical practitioners (Auerbach et al., 2013; Bodenheimer & Smith, 2013; Institute of Medicine, 2011). Internationally, NPs have provided cost effective health services particularly to rural communities, to significantly deprived communities, and to indigenous communities (Aleshire & Wheeler, 2012; Browne & Tarlier, 2008; Everett et al., 2009; Kaasalainen et al., 2010). The WHO (2008), Institute of Medicine in the US (2011), and the All-Party Parliamentary Group on Global Health in the UK (2016), have all advocated for the necessity of developing nursing, including the NP workforce, to improve health, promote equity, and support economic growth.

### **Scope of practice and educational preparation**

Issues of definition of scope of practice are problematic internationally. The International Council of Nurses NP/APN Network estimates that approximately 70 countries have been identified as having emerging or existing advanced practice nursing/NP roles (NP/APN Network, 2017). While all NPs are expected to be expert nurses who sit within an advanced practice nursing framework, there is no consensus internationally regarding educational

preparation nor definition of scope of practice (Pulcini, Jelic, Gul, & Loke, 2010; Sheer & Wong, 2008). The International Council of Nurses (ICN) provides the following:

“A NP/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master’s degree is recommended for entry level.” (International Council of Nurses, 2009)

Confusion arises when comparing NPs between countries, as well as between states within the US and Australia, and provinces in Canada. Clinical nurse specialists are included in the ICN’s definition, yet in New Zealand, clinical nurse specialists have a RN scope of practice. Not all countries prepare nurses at master’s level, and prescribing is not necessarily a requirement for NP scope of practice. Pirret (2013) warns that when reviewing research and models of care involving NPs it is important to understand the scope of practice in order to be able to interpret the findings for other contexts, including New Zealand. The lack of international consistency potentially results in confusion, with conflicting texts circulating regarding the scope, competencies, and outcomes of NPs and NP practice.

The Institute of Medicine (2011) reported that regulatory scopes of practice for NPs across the US varied from state to state and were a key barrier to NP employment and growth. While some states were considered to have kept pace with health care demands, including the need for NPs to be authorised prescribers without physician oversight or collaboration, many others lagged behind (Christian, Dower, & O’Neil, 2007). This “patchwork of state regulatory regimes” (Institute of Medicine, 2011, p. 5) has ultimately resulted in reduced access to health care (Kuo, Loresto Jr, Rounds, & Goodwin, 2013).

The US and Australia, and some provinces in Canada, have educational programmes that prepare NPs at master’s level. These master’s programmes have core components, including

pharmacotherapy, pathophysiology, and advanced health assessment and diagnostics. However, in the US and Canada, NPs choose a pathway in a particular area of health, such as children, adult, older adult, women & men's health, and mental health. The focus of their programmes is, in the main, to prepare NPs to work in an area of primary health care practice, including clinics, private practice, health centres, and out-patient hospital departments (Canadian Nurses Association, n.d.; Fang, Yan, Arietti, & Trautman, 2015). In addition, at the end of the programme, there is a comprehensive examination administered by the student's regulatory authority, which students must pass to graduate and be registered as a NP. Both Canada and the US have now introduced the Doctorate of Nurse Practice.

In Australia, following completion of a master's degree, nurses apply for endorsement as a NP. They are required to submit evidence on clinical practice hours worked at an advanced level (5000 within the past six years), a curriculum vitae, ongoing compliance with National Competency Standards, and continuing professional development (Nursing and Midwifery Board of Australia, 2016). In 2010, under the Australian Health Practitioner Regulation Agency, the Nursing and Midwifery Board of Australia became accountable for the registration of all nurses and NPs. Prior to this, each State had its own nursing regulatory Act leading to differences in legislation, and therefore, NP practice across the country (Middleton et al., 2016). Australia now has one set of NP standards used for regulatory, educational, employment, and monitoring purposes. However, despite this, the NP's scope of practice in any given local setting continues to be conditioned by Federal, State, and Territory legislation, and the governance processes of local health organisations and networks (Scanlon, Cashin, Bryce, Kelly, & Buckely, 2016). Scanlon et al. described how "these limitations to the full expression" (p. 140) of the NP scope of practice, affected the critical mass of NPs in the country to achieve universal access to health care services.

### **Area of practice: Rural primary health care**

In 2017, the American Association of Nurse Practitioners stated there were 234,000 NPs, a growth of 66% since 2008 (American Association of Nurse Practitioners, 2017), though it seems at least 20% are not employed as NPs<sup>20</sup>. While 89.2% of NPs have been certified to work in primary care, this includes those who are working in hospital outpatient clinics and in long term care facilities (American Association of Nurse Practitioners, 2017). Therefore, approximately 52% of the NP workforce in the US work in primary health care settings (as described in chapter one) (Agency for Healthcare Research and Quality, 2014a), with NPs accounting for 19% of the total primary care professional workforce (Agency for Healthcare Research and Quality, 2014b). Through the US National Provider Index data, 15.2% of NPs indicated they were practising in rural locations (Skillman, Kaplan, Fordyce, McMnamin, & Doescher, 2012). Further, NPs are much more likely to work in rural, underserved populations than doctors (DesRoches et al., 2013; Everett et al., 2009).

In Canada, the picture varies across provinces, however most have developed NP services in rural settings. The NP movement in Ontario has been most successful and now has over 3160 NPs of whom 2364 work in primary health care, an increase of 44% since 2013 (College of Nurses of Ontario, 2017). With a total population in Ontario of 13.6 million people this gives a ratio of one NP in primary health care per 5700 people. This compares to New Zealand estimates of one primary health care NP per 35,000 to 40,000 people<sup>21</sup>. The NP success in Ontario can be attributed to strong nursing leadership, substantial support from the state Ministry of Health for both education and service establishment, and province wide consistency with tertiary education programmes (Adams, 2012).

In 2010, the Institute of Medicine in the US notably released a report *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine, 2011) which identified that nurses

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<sup>20</sup> Figures from Bureau of Labor Statistics (2016), the Kaiser Family Foundation (2017), and the US Department of Health and Human Services Health Resources and Services Administration (2010) indicate between 20% and one third are not employed as NPs.

<sup>21</sup> Figures estimated from Nursing Council data.

needed to be at the forefront of the evolution of healthcare and that NPs had the potential to grow at a relatively rapid pace. This document has been utilised across the world by those leaders and policy makers advocating for the NP workforce. Additionally, the introduction of the Patient Protection and Affordable Care Act (2010) (colloquially known as ObamaCare) aimed to increase access to health care for an additional 32 million citizens of the US. The numbers of physicians have remained inadequate to meet health needs in primary care, despite a prepared and autonomous NP workforce. Weiland (2015) contends that NP autonomy remains a “political issue deeply embedded in the culture of health care” (p. 95). However, the ratio of NPs to physicians is predicted to continue to increase, which will have implications for health service delivery systems (Auerbach, 2012). It is perhaps the ability of governments and health organisations to adapt to, and incorporate NP services which is proving to be one of the greatest challenges both in the US and elsewhere, including New Zealand.

Internationally, in rural and underserved areas, NPs are often the predominant providers of primary health care services. Nurse-managed health centres were established in the US to provide health services in deprived, rural, and indigenous communities where there was limited, or no access to affordable primary health care services (Hansen-Turton et al., 2010). Nurse-managed health centres offered a solution to the health crisis in the US, delivering interdisciplinary care and optimising the full scope of nursing practice (Holt et al., 2014). The National Nurse-Led Care Consortium now supports over 250 nurse-managed clinics across the US and provides 2.5 million patient encounters annually (Hansen-Turton et al., 2010). Their website states:

Because of their education and their community connections, advanced practice nurses [NPs] today are able to deliver high quality and cost-effective services to our most vulnerable populations, the poor and the uninsured. Our member health clinics, run by nurse practitioners,

demonstrate this by providing community-based care that is sensitive to patient needs and concerns. (National Nurse-Led Care Consortium, 2016).

The Consortium described that their model of care works because they focus on local communities where “national health policy and social reality meet”; that they connect health with social service provision; and they work in partnership with the community to improve health equity. Their model reflects the social justice framework within which NPs work, and highlights the opportunity for rural NPs in New Zealand. Hansen-Turton (2007) from the National Nurse-Led Care Consortium has visited and worked with New Zealand nurse leaders to promote NP-led primary care services.

Models of NP practice have been limited in the US, Canada, and Australia, by access to diagnostic tests and restrictions on prescribing. From survey material of NPs working in underserved and rural areas of the Mississippi Delta in the US, researchers stated:

While NPs are a valuable asset to primary care services, unfortunately their ability to practice to the full extent of their educational preparation is often limited by unnecessary restrictions, including such barriers as equitable reimbursement and prescriptive authority. (Kippenbrock, Lo, Odell, & Buron, 2015, p. 711)

A discourse analysis by Australian researchers concurred, explaining a similar gap between policy and the reality of the implementation of the NP role in rural and remote areas (C. Turner, Keyzer, & Rudge, 2007). They described how the actuality of the NP role had not met the vision of the nursing profession, with the rural nursing voice silenced by dominant managerial and bio-medical discourses.

In Ontario, an earlier study examining a collaborative model of practice between family doctors and NPs concluded that NPs were being underutilised (Way, Jones, Baskerville, & Busing, 2001). Dahrouge et al. (2014) undertook a cross-sectional study of 21 community health centres involving the full-time equivalents of 53 family physicians and 41 NPs with

nearly 45,000 patients. The NPs and doctors had similar work schedules between clinical and non-clinical time. Nurse practitioners saw higher proportions of patients in vulnerable groups, and tended to provide more care to women and children. The family physicians tended to treat more patients with serious acute or chronic illnesses. The researchers concluded that the relaxation of restrictions both in prescribing and ordering tests, combined with improvements to NP training and continuing education, may lead to NPs seeing more medically complex patients.

There is an ongoing tension expressed in the literature between the health needs of the local communities, the lack of doctors, and often the difficulty in developing the NP role to realise its full potential, including autonomous prescribing practice (Kippenbrock, Buron, Odell, & Narcisse, 2014; Kleinpell et al., 2014; Scanlon et al., 2016; C. Turner et al., 2007). At the same time rural nurses may continue to work in an expanded scope of practice, filling the health service gaps, without the appropriate educational and regulatory framework, nor appropriate remuneration (Hegney, 2007). From the experiences of the US and Canada, NPs have tended to provide health services in areas that are remote, rural, and underserved by other primary health care practitioners. However, Browne and Tarlier (2008) describe the risk of NPs replacing doctors and consequently being confined to an “ineffective” narrow biomedical primary care model. They warn:

As politicians and policy-makers call on NPs to resuscitate an overburdened healthcare system that is increasingly affected by neoliberal policies and agendas, NPs must aim to provide primary care in ways that mitigate the impact of health and healthcare inequities using critical social justice approaches. (p. 88)

Nurse practitioners must deliver care that is demonstrated to be contextualised within the socio-economic determinants of health. When working within such a social justice paradigm, NPs have the opportunity to transform health service provision and address unmet health need (Kooienga & Carryer, 2015).

## **Rurality and health inequalities in New Zealand**

Social justice and reducing inequalities in health is central to my research with the premise that NPs are an appropriate workforce to deliver health services to underserved and marginalised populations in New Zealand. The focus for my research was rural New Zealand where people experience reduced access to health services and diminishing numbers of general practitioners. In this section, I provide the information and data to establish the context for NP work in rural New Zealand, including the extent of health inequalities.

### **New Zealand and the population**

New Zealand, or Aotearoa, is a long and narrow country of over 1600km length situated in the southwestern Pacific Ocean. It consists of two main islands - the North and the South Islands - which have diverse climates, geography and flora. Three quarters of New Zealand's 4.8 million population live on the warmer North Island, with 1.5 million of those living in the Auckland region. Only four other cities, including the capital, Wellington, have a population of over 100,000 people. Farming, tourism, and forestry are New Zealand's top exports (Statistics New Zealand, 2015b).

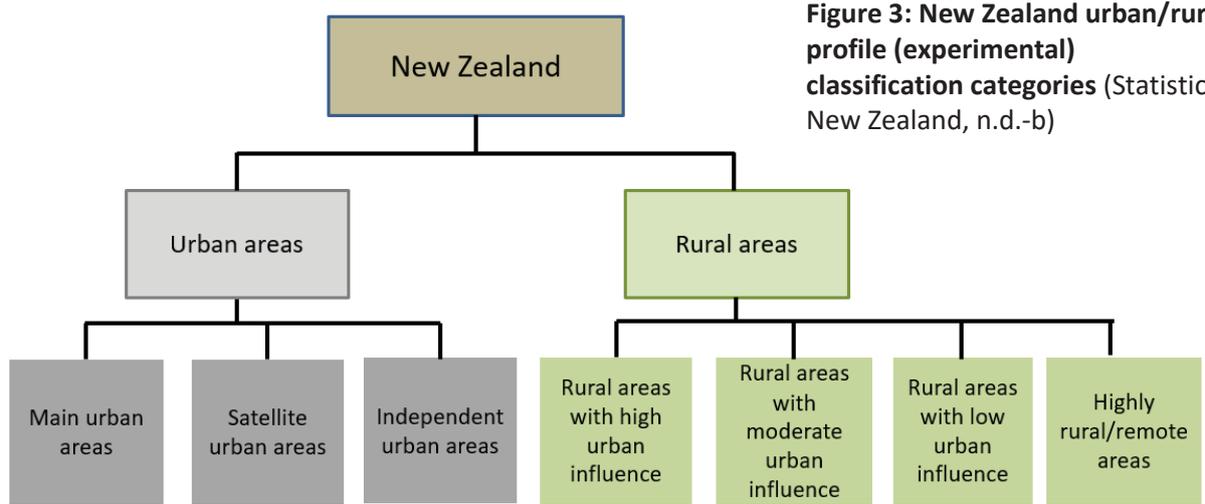
New Zealand is an increasingly and diverse multicultural society with people from different ethnic, cultural and linguistic groups from across the world. People identified with the following four main ethnicities: 15% Māori, 74% white European, 7% Pacific peoples, and 12% Asian (Statistics New Zealand, 2013). Population growth is rapid. The number of very elderly (aged 85 years and over) has grown by 29.4% in the past seven years, and the majority still live in their own homes (Ministry of Social Development, 2013; Statistics New Zealand, 2015a). The pattern and economic threat of a rapidly increasing older population in New Zealand is similar to other developed countries (Blakely et al., 2014; Swartz, 2013). While both Māori and Pacific populations are younger than the European population, and have a shorter life expectancy, for both men and women across the major ethnic groups life expectancy is increasing, in turn creating an ethnically diverse older population. As a

consequence, complex co-morbidities, dementia, disability, and mental health issues are rising.

### **Rurality and the health of the population**

Approximately 14% of the population live in rurally defined areas, and a further 10% in small towns independent of main urban centres (Statistics New Zealand, 2006). Nearly 100,000 Māori live in rurally defined areas, such as in Northland, in the East Coast region of the North Island, and in central areas of the North Island. These are generally deprived communities, with poor housing, reduced income, and poorer access to health services and other resources which promote health (Maré, Mawson, & Timmins, 2009). Such areas have the poorest health statistics across New Zealand (Ministry of Health, 2012). The majority of the remaining rural population are Pākehā (white European), with only 2.5% of Pacific peoples and 3.8% of Asians living rurally (Statistics New Zealand, 2016; Statistics New Zealand & Ministry of Pacific Island Affairs, 2010).

The purpose of defining rural in health policy is to fairly distribute resources, particularly to those underserved communities with higher health needs (Hart, Larson, & Lishner, 2005). Elements of definition may include geographical isolation, population density, and access to urban centres. However, the definitions often fail to incorporate the considerable variations in the demography, economics, culture, and environment of different rural communities (Hart et al., 2005). The urban/rural classification in New Zealand has been critiqued as not being fit for purpose for planning health services to meet rural health needs (Fearnley, Lawrenson, & Nixon, 2016). The current classification of the urban/rural profile in New Zealand (shown in Figure 3 overleaf, page 64) highlights the issue.



**Figure 3: New Zealand urban/rural profile (experimental) classification categories** (Statistics New Zealand, n.d.-b)

For example, there are 89 independent *urban* areas which are small towns or settlements where the majority of the working population are employed. The average population size is 4,900 (range 660 to 26,745) (Statistics New Zealand, n.d.-a). Access to primary care and community services is variable depending on size, and travel to the nearest urban areas can be considerable. Over 10% of New Zealand’s population lives within these small towns.

Excepting a few of the larger towns that have small hospitals, the majority of independent urban areas are isolated, with lengthy transport times by road to the nearest secondary health service. Of particular relevance to rural New Zealand and small urban towns is transport. Rural people rely on roads for transport, with either minimal or no public transport options to and from urban towns. Road networks linking urban areas often cross challenging terrain, with many roads in rural areas unsealed. Road closures, cutting off communities, range from days to weeks, due to earthquakes, land slippage, fallen trees and power lines, and accidents, and are not uncommon.

Rurality adds its own complexities to health. However, there is no direct relationship between simply living rurally and health outcomes, and increasingly there is greater understanding of the many contextual factors at play (Ministry of Health, 2007; Pearce & Dorling, 2006). The health of the rural New Zealand population is socio-economically

diverse, and often within communities the population ranges across the deprivation centiles. What seems to be critical is understanding the importance and resilience of each community, and identifying the neighbourhood characteristics that support a healthy population (Pearson, Pearce, & Kingham, 2013). Historical, socio-economic, environmental, occupational, cultural, climatic, and geographical characteristics, as well as issues of isolation, transport, availability of internet access, and access to recreational, educational, and food shopping facilities all contribute to rural health (Howie, 2008b; National Health Committee, 2010; Pearce, Witten, Hiscock, & Blakely, 2008; Wakerman, 2004).

The importance of the environment on people's health has been long recognised. However, there is now growing knowledge over the past decade of what are called socio-spatial, or geographical, inequalities in health (Bowie, Beere, Griffin, Campbell, & Kingham, 2013; Pearson et al., 2013). Physical or infrastructure characteristics (such as access to alcohol, tobacco or gambling, healthy or unhealthy food, health services, and education), and social characteristics (such as social fragmentation, and cultural participation) all may affect the resilience of a community. Such characteristics can drive inequalities between individuals, social and ethnic groups, as well as between geographic groups (Pearce, Richardson, Mitchell, & Shortt, 2011; Pearson et al., 2013).

Further, it is the more deprived communities where lifestyle factors more significantly pose a threat to health. Such factors include obesity, recreational drug usage, alcohol and gambling problems. It is often in deprived communities that people have greater access and closer proximity to outlets supplying goods which negatively affect health (Bowie et al., 2013). Substandard housing related to poor sewage systems, contaminated rooftop drinking water, and damp, cold conditions adversely affect health and increase hospitalisations (Howden-Chapman et al., 2007; National Health Committee, 2010; Rauh, Landrigan, & Claudio, 2008). It is in these particularly deprived communities where NPs can

add value to existing health, social, and community services through their intersectoral work.

Life expectancy for rural Māori is less than for urban Māori, whereas for Pākehā, rural life expectancy is slightly longer than for urban Pākehā (National Health Committee, 2010). The independent urban areas, are often remote and have poor access to secondary services, while rural high urban influence areas are in close proximity to a range of health and secondary services. The report *Mātātuhi Tuawhenua: Health of Rural Māori* (Ministry of Health, 2012) demonstrates further the issue in defining rural and urban populations according to the classification system. For example, Māori in independent urban areas had a third higher cardiovascular mortality than did Māori living in rural areas with a high urban influence.

### **Health inequality and health inequity**

Health inequality is the measurable difference in health status between groups of people within and between countries. Health inequity, or health disparity, reflects an unfair distribution of health risks and resources. Health inequities are preventable, unnecessary and unjust, and shaped by social, economic, and political forces (Arcaya, Arcaya, & Subramanian, 2015; Commission on Social Determinants of Health, 2008; Whitehead, 1992). Over recent years, there has been global acknowledgement that key to achieving health equity requires cross-government policy coherence (Commission on Social Determinants of Health, 2008; Haynes et al., 2013). Health equity should be central to *all* policies, and social justice should be at the heart of *all* policy-making (Marmot & Bell, 2012).

Reducing inequalities and improving health for all are the ultimate goals of primary health care globally and in New Zealand (Commission on Social Determinants of Health, 2008; A. King, 2001; Marmot, 2005; Whitehead, 2007; WHO, 1978, 2008). Health inequalities may also arise from inequities within health services themselves, including access, burden of payment, location of services to rural, deprived and indigenous communities, models and

quality of service delivery, and clinical practice (Came, 2014; Sheridan et al., 2011; WHO, 2008). New Zealand is no exception, where Māori have poorer life expectancy than non-Māori (Woodward & Blakely, 2014).

New Zealand is described as a bicultural nation based upon its founding document, the Treaty of Waitangi, *Te Tiriti o Waitangi*, and is central to New Zealand's constitutional framework (Department of Health, 1992; O'Connor, 2007; Te Puni Kōkiri, 2001). The principles of the Treaty of Waitangi began to be incorporated into health service policy, education and practice from 1988 (Department of Social Welfare, 1988; D. Wilson & Haretuku, 2015). However, health inequalities for Māori have remained at an internationally unacceptable level, despite what has been considered substantial progress in health over these past few decades (Blakely et al., 2005; WHO, 2008).

Gaps in life expectancy and infant mortality rates closed between Māori and Pākehā over the first decade of the 21<sup>st</sup> century, but the gaps continued to increase for smoking prevalence, obesity, and suicide (Marriott & Sim, 2014). Māori have a reduced life expectancy, and increased rates of morbidity across the age continuum, including long term conditions, cancers, oral health, and rheumatic fever (Matheson & Loring, 2011; Tobias, Blakely, Matheson, Rasanathan, & Atkinson, 2009; Woodward & Blakely, 2014). Both Māori adults and children have an increased rate of hospitalisation following late presentation, and are more likely to be admitted for conditions that are considered to be avoidable, such as asthma, cellulitis, dental abscesses, and angina (Health Quality & Safety Commission New Zealand, 2015a, 2015b). Further, health systems in New Zealand often failed to provide services for Māori with long term conditions in the face of known health inequalities (Sheridan et al., 2011).

Across the socio-economic determinants of health, Māori fare far worse than Pākehā. Māori experience lower income, poorer housing, unemployment, and lower educational achievement (Ministry of Health, 2015c). Low health literacy is associated with poorer

health outcomes and higher mortality (Bostock & Steptoe, 2012; Greenhalgh, 2015). Four out of five Māori males and three out of four Māori females have poor health literacy skills, and those who live in rural locations have the poorest health literacy skills (Ministry of Health, 2010). As with many indigenous peoples across the world, while the root causes of poor health are these social determinants, a range of other indigenous specific factors relating to culture and colonisation, including racism, the loss of language and land, and environmental disconnectedness, have a negative effect on indigenous health (M. King, Smith, & Gracey, 2009).

As a consequence of both indigeneity and poor socio-economic determinants, issues such as obesity, gambling, and alcohol are more prevalent for Māori (Baxter, Kingi, Tapsell, & Durie, 2006). Further consequences include higher rates of mental health issues, Māori women being at least twice as likely as other women to experience domestic or interpersonal violence, higher rates of suicide, child abuse and teenage pregnancy (Baxter et al., 2006; Ministry for Women, 2015). In 2012, 51% of all prisoners were Māori and 33% Pākehā (compared to overall population of 15% and 74% respectively) (Statistics New Zealand, 2012). As with other nations with indigenous populations, such inequities are a travesty of social justice.

Despite an abundance of health statistics and information on poorer lifestyles, education, and health outcomes for Māori, the bulk of health service delivery models in the community have remained largely unchanged. Western biomedical models of general practitioner-led primary care continue to dominate (Cumming, 2011). While there are examples across the country of more innovative service delivery for Māori, through various primary health organisations such as an outreach NP led service (Bruning, 2012), these are few and far between, and with little evaluation. The rhetoric remains strong in New Zealand health policy - to reduce inequalities and improve population health - but the realities of actually

making a difference to Māori health and population health are far from reality (Ashton, Tenbenschel, Cumming, & Barnett, 2008).

Māori models of health are very different to the reductionist biomedical western models that dominate the current health care system, for example, *Te Whare Tapa Wha* (Durie, 1998), and *Te Wheke* (R. Pere, 1991). The Māori regulated health workforce is small and not proportionally reflective of the Māori population. 6.8% of RNs and 3.2% of all doctors in New Zealand are Māori (Medical Council of New Zealand, 2014; Nursing Council of New Zealand, 2015b). The onus must be on all health practitioners to bridge the gap between western and Māori models of health. However, with a focus on reducing health inequalities and social justice, I would argue that this is the space that NPs can work and be highly effective in meeting the health needs of those disadvantaged and rural populations. Using their advanced nursing competencies and prescribing, NPs can utilise their biomedical knowledge of health and apply it using holistic Māori approaches of health, and in so doing, bridge the gap (Browne & Tarlier, 2008). There is a need to shift care away from high cost, reactive medical and specialist services to proactive health care service delivery models which are well coordinated with other social and community services, and focus as much on wellness as illness (Cumming, 2011; Oliver, Foot, & Humphries, 2014). Nurse practitioner services can assist in attaining such transformational changes (Carryer & Adams, 2017).

## Summary

This chapter has explored the development of advanced practice nursing and the NP workforce, both in New Zealand and internationally. The evidence provided was purposefully selected to demonstrate the opportunity for NPs to deliver services across the health care sector, and particularly in rural, underserved areas, where health inequalities continue to persist. Important documents, such as the Institute of Medicine report (2011)

and the more recent All-Party Parliamentary Group on Global Health (2016), powerfully direct countries to acknowledge the contribution nurses and NPs can make to global health issues.

There is now incontrovertible evidence that NPs provide a level of care that is at the very least equivalent to doctors, and may be superior across health outcomes, including patient satisfaction, hospitalisation rates, and potentially, overall mortality (for example, Martínez-González et al., 2014; Swan et al., 2015). There is a growing concern that the current biomedical model of health is not meeting needs of those people with long term conditions, indigenous people, those who are marginalised, and people living in rural and underserved areas (for example, Browne & Tarlier, 2008; Commission on Social Determinants of Health, 2008; Hansen-Turton et al., 2010; Sheridan et al., 2011). Nurse practitioners are a potential solution to transforming health services and meeting the health care needs of such communities (Browne & Tarlier, 2008; Carryer & Yarwood, 2015; Kooienga & Carryer, 2015). In Carryer and Adams (2017) we argued that to continue to focus on evidence that demonstrated equivalence with medicine limited the potential and understanding of NPs work.

Contemporary NP services are located on a historical trajectory within a social justice paradigm, often developing in underserved and rural areas (for example, Everett et al., 2009; Holt et al., 2014). While NPs are becoming significant providers of health care in these areas, legislative and regulatory barriers remain which impede the NP's ability to work at their optimal scope of practice. Given the considerable concern about health inequalities, the increasing burden of long term conditions, and the reducing medical practitioner workforce, it is surprising that an obvious solution to improving access to health through NPs is not being widely supported and implemented.

New Zealand has carefully established the parameters and processes for implementing the NP role based upon international policies and evidence. The rationale for NPs has been

clearly established through population health requirements to address health inequalities and provide health services in underserved areas. Government policy has stated the need to reduce health inequalities and develop the nursing workforce in both the Primary Health Care Strategy (A. King, 2001), and the New Zealand Health Strategy (2016c). Yet there is little evidence to indicate that recent policy is actually making any difference to the health of Māori (Matheson & Loring, 2011; Woodward & Blakely, 2014). Western biomedical models of general practitioner-led care dominate (Cumming, 2011) despite the ongoing reduction in numbers of general practitioners.

Through this chapter, the texts have shown the value, relevance, and evidence for NPs working in primary health care, and particularly in marginalised and rural populations. Additionally, there is a robust regulatory, educational, and legislative framework established in New Zealand. Yet there is no overtly agreed plan for implementing the NP workforce at governmental level, and the numbers of NPs in rural primary health care remain small. By applying the ontology of IE, certain texts and discourses will be more powerfully organising primary health care provision and limiting the development of the NP workforce. In the following chapter I describe IE as the approach to inquiry.

## Chapter Three

### Approach to Inquiry: Institutional Ethnography

#### Introduction

The approach to inquiry I chose to use – institutional ethnography (IE) - was introduced in chapter one to support my intention to maintain epistemological congruency throughout the thesis. To achieve congruency in qualitative research, the researcher needs to link and connect ideas so there is a “discernible fit between the ideas arising from the entire research inquiry” right through the research process to show that the “application and progression of ideas [is] ‘faithful’ to the foundational ideas of a respective methodology” (B. Taylor, 2013, p. 5). Achieving congruency then should result in a research report that the reader finds more comprehensible, believable, trustworthy, and worthwhile. This chapter describes the approach to inquiry, showing how it fits with the central concern of this thesis – to critically examine the work required to establish NP services in rural primary health care in New Zealand.

Institutional ethnography was founded by Dorothy Smith during the 1970s. It has been succinctly described as a “Marxist-feminist, reflexive-materialist, qualitative method of inquiry” (Hussey, 2012, p. 2). In essence, the ontology of IE is that the social world is coordinated textually. The ruling relations are “fields of socially organised activity” (Smith, 1999, p. 75) that textually, coordinate, organise, or even control people’s actions and experiences. As people engage with the texts, which maybe visual, oral, or written, they are connected or hooked up into the ruling relations. The enactment of texts in the local situation leads to the replication of people’s activities across similar, though geographically separate settings. As people engage with the ruling relations, they may perpetuate or alter

them in some way. Inquiry then is concerned with showing and explaining (explicating) how the ruling relations are coordinating the work of people in the local situations. In my research, the 'people', or primary informants, are the nurses and NPs. Ultimately, the purpose of an IE is to "reorganise the social relations of knowledge of the social" (Smith, 2005, p. 29), and therefore to provide insight into possibilities for change in the future.

At the time of choosing IE to guide this research, it had not been used in New Zealand, and formed the basis of an article aimed at introducing IE to the New Zealand nursing audience (Adams et al., 2015, see Appendix A). Institutional ethnography is considered an emergent mode of inquiry where researchers will need to adapt, revise, and improvise as IE is used in new applications (DeVault & McCoy, 2012). I hope that through this inquiry I may add to the growing body of knowledge about IE.

To begin, I have chosen to describe my entry point to, and "discovery", of IE. I believe this has two uses in my thesis. Firstly, the process of identifying IE as an appropriate approach to inquiry demonstrates the validity and congruency of my choice of IE; and secondly, it highlights how I have used IE, and where the potential lies to add to the body of knowledge about IE. Through this chapter I provide an overview of IE, including an overview of the development of IE. I describe how ruling of the social world is achieved through texts, and the epistemological position of IE as a materialist-feminist inquiry. Throughout the chapter I draw on institutional ethnographic research, and in the final section provide examples of further research showing how the ruling relations are explored.

## **My "discovery" of institutional ethnography**

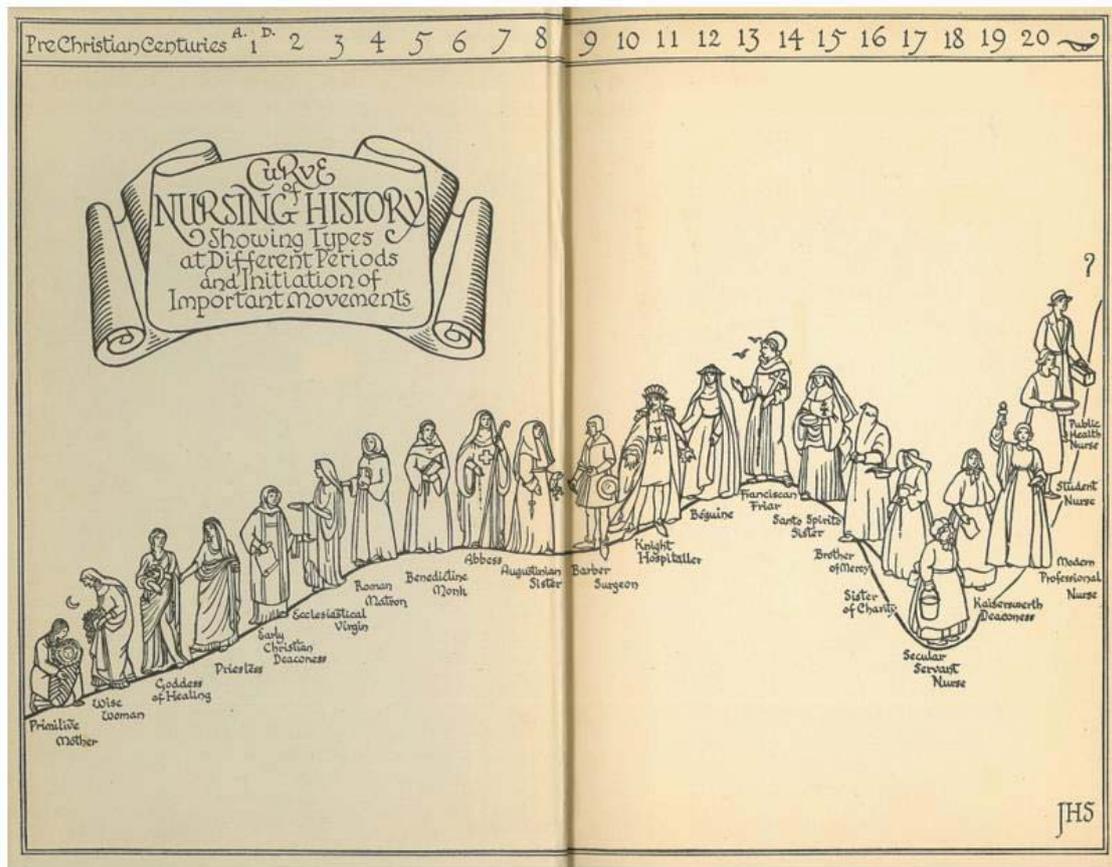
At the outset of this project I was concerned to ensure that I used an approach to inquiry that fitted with my own beliefs and assumptions about how the world of nursing worked. In chapter one I described my entry point to this study as a nurse who wanted to become a NP,

yet I experienced various moving and poorly differentiated obstacles from a range of sources that I could not easily understand or explain. I began my study with the intention of discovering what was happening in order to find ways of increasing the number of NPs working in primary health care in New Zealand. Finding an appropriate approach to inquiry became a very significant and enjoyable part of my doctoral journey. I include this short section here, where I identify pivotal ideas and concepts with the intention of providing insight into why I chose to use IE, and how I have used IE for my study.

I had an interest in the history of nursing, and the status of women as carers over centuries and millennia. I had been struck by a drawing inside the front cover of a book by Lavinia Dock and Isabel Stewart showing the “curve of nursing history” beginning in pre-Christian times (Dock & Stewart, 1932)<sup>22</sup> (see Figure 4 on following page 75). This “curve” depicted to me two valuable points. Firstly, the progress of nursing has not always been in an upward direction; and secondly, that nursing and caring have been at the mercy of the religious, political, economic, gendered, and social governing and ruling of the time. The Dark Ages from the thirteenth century through to the mid nineteenth century is shown as a downward trend on the curve. This was a time where women healers and midwives were subjugated to a position of subservience, barred from entering European universities because of their sex, and at times persecuted and punished by the ruling governing and religious forces (Ehrenreich & English, 1972; Minkowski, 1992).

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<sup>22</sup> I have a copy of the 3<sup>rd</sup> edition. The first edition was published in 1920 by G.P. Putnam’s Sons.



**Figure 4: Curve of Nursing History** (Dock and Stewart, 1932, inside cover)

Dock and Stewart’s drawing implies progress since the advent of the “modern professional nurse”, and later “public health nursing” which developed through the first wave of feminism at the turn of the nineteenth and twentieth centuries. Yet nursing since then has not had a smooth progressive journey. Political ideology, war, economic depression, the rise and power of modern medicine, feminist movements, biotechnology, and pharmaceutical developments have all powerfully affected nursing’s development as a profession (Andrist, 2006; Roberts & Group, 1995; Wolf, 2006). An inquiry that examined the development and implementation of NP services for me needed to include the opportunity to critique the contemporary ruling forces of the time.

Michel Foucault’s work offered a useful understanding to me of the power of organisations in society. The capitalist labour process, driven by the Industrial Revolution (1740-1860), resulted in the need for the organisation of labour on a large scale (factories, prisons,

hospitals, police, judiciary, education). Foucault described how the state exercises its power to control and govern the people using administrative mechanisms and knowledge structures (called disciplinary knowledge) (Foucault, 1977). The apparatuses of social control, including governing bodies, the law, health, education, and professional organisations, maintain and enhance power over people's everyday lives, through disciplinary techniques and surveillance, resulting in the production of subjected, docile bodies. Such concepts have been used to explore and understand aspects of nursing (for example, Cowley, Mitcheson, & Houston, 2004; Holmes, 2001; Perron, Rudge, & Holmes, 2010; St-Pierre & Holmes, 2008).

For Foucault, power and knowledge are inextricably linked. Power is dynamic, pervasive, diffuse, subtle, and circulates through the social world. Importantly, power and knowledge can be productive as well as constraining (Foucault, 1980). My experiences of working as a nurse in a range of positions and settings had taught me that power and knowledge are exercised by medical, managerial, and nursing hierarchies and discourses. Yet gaining knowledge and revealing how power is enacted, opens up possibilities for new ways of working in health. Foucault's work provided insight that if I wanted to understand the difficulties faced by intending NP candidates and NPs working in primary health care in rural New Zealand, then I needed to explore how the apparatuses of social control were indeed controlling their experiences and everyday lives.

Social control in society is gained and perpetuated through ideology (a Marxist term) or discourse (a Foucauldian term). Ideology, Marx believed, was established by the dominant classes to control society, and functioned to mystify and obscure people's actual existence (the material conditions of their lives). This process then concealed the possibility of change and reduced the likelihood of dissent from the subordinate classes (Marx & Engels, 1970). Ideology therefore legitimised those ruling forces who were in a hegemonic position. People accepted their class position in society and that the social world was unfair and unequal.

For Marx, ideology was the superstructure of a society representing the dominant ideas, conventions, norms, and culture of the particular era.

Central to Marx's philosophy was social justice. Minority groups, indigenous people, and those disadvantaged through economic and social structures are oppressed in our society resulting in marginalisation, and health and social inequalities. Over the past one and a half centuries, nursing has demonstrated its ability to work in areas underserved by medical practitioners. At times, as a female-gendered profession, nurses have aligned themselves with feminist ideals and principles to promote social justice (J. L. Thompson, 2014). As described in chapter two, underpinning much of the work of NPs in rural and marginalised communities has been a focus on social justice. Further, addressing health inequalities through providing equity of access to health services is an indicator of NP competency in New Zealand (Nursing Council of New Zealand, 2017a). The purpose of my work, whether as an educator, leader, or clinical nurse, has been to promote health outcomes and improve access to quality health services. Achieving social justice has driven my interest in NPs and therefore, I wanted an approach where social justice remained central.

Additionally, nurses themselves have often struggled within a system dominated by medicine, and more latterly, also by New Public Management (Griffith & Smith, 2014a; Group & Roberts, 2001; S. Newman & Lawler, 2009; Rankin & Campbell, 2006). Feminist research methods from the 1960s were developed to challenge inequality arising through sexism, racism, colonialism, class, and gender (Naples, 2003). Central to feminist research is the need to produce knowledge that begins from the standpoint of those living the experience, from their "situated knowledges" (Haraway, 1988, p. 575), who have been marginalised in some way by those dominant institutions of society. Given the actual struggles that I and other NPs had experienced, I felt required to use an epistemology that began from the materiality of people's existence – the actual experiences of the NPs and NP candidates – and which explored the ruling forces.

Foucault further developed Marx's ideology, terming it discourse. Discourses are a coherent set of ideas, beliefs, and principles that circulate through society (Foucault, 1981). Foucault specifically noted the link between power, knowledge, and language. He described that "each society has its regime of truth, its 'general politics of truth'" (Foucault, 1980, p. 131), where certain discourses are accepted and made to function as true. Such dominant and prevailing discourses are perpetuated by society, both by the people as well as the social apparatuses of control. Peoples subjectivities are discursively constructed, necessary to maintain control and organisation within society. For example, since the mid twentieth century there has been a shift in health policy from welfarism to neoliberalism. The dominance of the neoliberal discourse, through the introduction of New Public Management has constructed the subjectivities of both health professionals and consumers within health systems through the drive to increase efficiency and reduce costs (Ayo, 2012; Teghtsoonian, 2009).

Critiques of modern medicine, such as Ivan Illich's *Medical Nemesis* (1976) and Eliot Freidson's *Profession of Medicine* (1970) have argued that modern medicine is a form of social organisation which serves its own interests, rather than the interests of the people. Illich argued that through 'diagnostic imperialism' medicine organised people's lives into a series of risks, such as newborn or menopausal, all of which required medicine's input, reducing the autonomy of the population. These texts were fundamental in developing my own consciousness. I read Illich as an undergraduate at the University of London, and returning to his work again at the start of my study further grounded my own beliefs about the operations of medicine in our society. Such expositions identified the importance of using an inquiry that could critique the social organisation of health, allowing for the exploration of other ways of doing things.

Using the above knowledge and ideas, I mapped what I believed were the key ingredients of an epistemology for my inquiry to critically examine the work required to establish NP

services in rural primary health care in New Zealand. Against my ideas, I explored a range of theories, epistemologies, and methodologies. It was through this process that I “discovered” the existence of institutional ethnography, and as I read more and more, realised that IE was an approach to inquiry that would enable me to undertake my study.

## **Dorothy Smith: Development of institutional ethnography as an alternative sociology**

Dorothy E. Smith (born 1926) was born in England, and has lived and worked in Canada for most of her adult life as a sociologist. She comes from a notable line of activists who have participated in feminist movements from Quakerism through to the women’s suffrage movement. This lineage has been described as a productive force in facilitating her to envision a feminist standpoint theory (Smythe, 2009)<sup>23</sup>. Smith has been pronounced “a world-renowned Marxist feminist scholar and activist and a formidable intellect” (Carroll, 2010, p. 9).

The second-wave of the contemporary women’s movement, during the Civil Rights Movement of the 1960s and 1970s, resulted in various scholars developing feminist perspectives in the context of “diverse struggles for social justice” (Naples, 2003, p. 13), including race, gender, sexuality, and ethnicity. Dorothy Smith, like other feminist scholars in the 1970s, was challenged to find new approaches to knowledge production that would result in more democratic social relations. Conventional social sciences were considered to

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<sup>23</sup> Dorothy Smith’s genealogy can be traced back to Margaret Fell (later Margaret Fox), a founder of the 17<sup>th</sup> century Quaker movement, an early feminist leader popularly known as the ‘mother of Quakerism’. Fell sought greater equality for women and wrote on the right of women to teach and preach scripture (D. E. Smith, 1978). She was imprisoned for her beliefs and pacifist activism. Both Smith’s grandmother, Lucy Ellison Abraham (nee Golding), and mother, Dorothy Foster Place (nee Abraham), were actively involved in the women’s suffrage movement in England (Smythe, 2009). Both were members of the Women’s Social and Political Union (WSPU), founded by the Pankhurst family in 1903, a militant movement with the slogan “Deeds not Words”. Like Fell, Smith’s mother was held in prison for her participation in militant demonstrations.

turn the “chaotic and confusing experiences of everyday life into categories of people in society” (Harding & Norberg, 2005, p. 2009). In turn, those causal accounts of who people were, how they behaved, what they did, enabled institutions to textually govern people’s everyday lives, meeting the needs of the institutions, rather than the needs of those most vulnerable groups. The social sciences were complicit in the exercise of power to control relations, including between men and women, black and white, heterosexual and homosexual, and so on.

During the 1970s while working at the University of British Columbia, Smith began articulating her feminist standpoint theory. As both a sociologist and single parent, Smith experienced a disjuncture, or what she described as a “bifurcation of consciousness” (Smith, 1987, p. 6), where her experience as a woman was being conceptualised from a masculine standpoint of ruling and privilege. She was “barred from inhabiting the taken-for-granted” places that men doing sociology inhabited (de Montigny, 2017, p. 337). She found this alienating and untenable. On the one hand she was a sociologist, participating in the masquerade of universality<sup>24</sup>, while on the other she was experiencing everyday life at home with children. She stated:

[T]he division I experienced in my working life was one that was replicated and reinforced in the sociology I practiced. I could not escape it; I could not find how to reassemble myself as a woman without changing it. I had to find a sociological practice that could begin in the actualities of people’s lives so that I could explore the social from there on, as it is brought into being in the same actuality. (Smith, 2005, p. 22)

In order to reconstruct how she connected with the world both as a woman and as an intellectual, Smith began “the process of unravelling the intellectual nets that trapped [her]”

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<sup>24</sup> Smith references the term from Joan Landes who discusses how masculine speech is aligned with truth, objectivity, and reason. Hence the male [in Smith’s case being a sociologist in an androcentric institution] can “masquerade ... behind the veil of the universal” (Landes, 1998, p. 143).

(Smith, 2005, p. 21). Here the foundations were laid for the development of IE as an alternative sociology.

Her early publications, *The Ideological Practice of Sociology* (Smith, 1974a), *A Women's Perspective as a Radical Critique of Sociology* (Smith, 1974b), and *A Peculiar Eclipsing: Women's Exclusion from Man's Culture* (Smith, 1978), explored the social world from a woman's perspective, challenging the dominant ideologies of society and sociology. Following her move to the University of Toronto, where she established the Centre for Women's Studies in Education with Roxanna Ng, Smith authored a range of groundbreaking texts. These included *The Everyday World as Problematic: A Feminist Sociology* (1987); *Texts, Facts, and Femininity: Exploring the Relations of Ruling* (Smith, 1990b); *The Conceptual Practices of Power* (1990a); and *Writing the Social: Critique, Theory and Investigations* (1999). In her 2005 book *Institutional Ethnography: A Sociology for People* (2005), Smith updated her terminology from a *sociology for women* to that of a *sociology for people*, clearly signalling that we must begin our understanding of the social world from the experiences or standpoint of people as they go about their everyday lives. Smith continues to work and publish (Griffith & Smith, 2014a,b; Smith, 2006c; Smith & Turner, 2014a), as an adjunct professor at the University of Victoria, British Columbia, and Professor Emerita at the University of Toronto.

Institutional ethnography as a sociology is proposed to be both an ontology and epistemology for social science inquiry. Smith (2005) defined ontology as a "theory of reality... of how the social is real... of how the social exists" (p. 52). Social reality exists in people's actual everyday activities and experiences. Indeed, it is those relations and interactions between people that establish the social world, both how we know it, and how we live in it (Campbell & Gregor, 2004). Reality can only be discovered from the actualities of people's lives.

However, the focus of IE is on the social, and not the individual. Individuals' everyday lives and actions are coordinated with others by the institutional ruling relations. The coordination is achieved by the replication of texts which reach across multiple similar, though geographically separated, local situations. In the local setting, individuals engage with those texts and in so doing are connected or hooked up into the ruling relations. People's everyday experiences and actions, often termed work, are being similarly organised or controlled. Smith intended the ontology of IE to provide a theory that helped social inquiry by guiding us as to what we might be observing, listening for, recording, and analysing (Smith, 2005).

As an epistemology, IE provides an approach to inquiry to learn and gain knowledge about our social world. Knowledge of how the world works begins from the experiences and actions of people in the local situation, and by exploring how these experiences and actions are being coordinated by the institutional ruling relations. Texts emanating from the ruling relations enter into the local situation and organise, coordinate, or control, people's everyday activities. Hence the aim of the inquiry is to make visible how we are connected with the ruling relations through those texts, and how we are 'hooked up' into the practices of ruling (Smith, 2005). In this process, the connections between people's experiences and the extended relations of ruling are mapped and explicated.

## **Text mediated ruling**

Contemporary society is ruled and governed textually (Smith, 2005). The ability to communicate *en masse* with people has been enabled through technology. Initially, this occurred with the advent of the printing press and the ability of institutions to produce multiple copies of written texts, such as newspapers, policies, orders, books, leaflets, and so on, for distribution across the population. Later on through the twentieth century, radio and television were added to the technologies for distributing texts. Then in the last few decades

the invention of the world wide web, and more latterly social media, has enabled rapid communication across the globe. The key point is that the texts are replicable, reaching people in multiple local situations. A text is anything that can be “read”. It is something that transmits some kind of informative message, whether that be written, sounded, spoken, visual, touched, or sensed. Texts could therefore include, for example, music, the arrangement of buildings or offices, artwork, photos, styles of clothing, and films. Discourse is carried and transmitted through these texts.

Text mediated ruling is an exercise of power to mobilise people’s concerted activities in society. While some texts maybe more obvious to us as we go about our everyday activities, mostly they are taken for granted or unknown to us (Smith, 2005). Rankin and Campbell (2006), to whom I shall return, used IE to show how the ruling relations of the health system in Canada were organising nursing activity through a particular coordination of objectified knowledge and technologies to achieve effective management. Particular software (as a text) exercised a sophisticated form of power over nurses and their work. The researchers found that the consciousness of nurses was being reconstructed, and that their work as nurses was being controlled by the software system, rather than utilising their own professional knowledge and values.

The ruling relations are a complex of discourses and texts that circulate within our social world. The state, institutions and organisations of health, law, science, education, religion, and media, professional bodies, agencies, and corporations, all produce discursively mediated texts that create a “web of relations through which ruling is achieved... The ruling relations operate by replacing people’s social experience with textual accounts of experience, which obscures and transforms what is known” (Bisaillon, 2012, p. 618). Smith describes how the ruling relations generate specialised systems of knowledge that include theories, concepts, technologies, and technical languages that serve to organise and shape the social world (Smith, 1999). People’s actions are coordinated or organised by texts,

resulting in people having similar experiences, despite being geographically disconnected. Texts are coordinators of a person's subjectivities (Smith, 2005). Our subjectivity is our sense of self, however, our subjectivities are textually and discursively produced and organised by the ruling relations.

Smith draws on Foucault's (1981) notion of discourse to describe how disciplinary knowledge is created that subordinates people and creates their subjectivities, such as mentally ill, drunk, criminal, or woman, black, lesbian. However, she departs from Foucault's ideas of discourse where the text is static and large-scale, and its materiality is lost. Rather, she develops her ideas where discourse includes texts and their intertextual conversation, and the ability of texts to actively coordinate the social world as they are taken up and used in local settings (Smith, 2014). She draws on the works of Bakhtin and Vološinov where language is "alive", active, and dialogic, allowing new forms of thinking to emerge (Roth, 2014).

Mikhail Bakhtin was a philosopher of language and a literary analyst. Bakhtin differentiates between two types of speech genres – primary and secondary. Primary speech genres he calls "utterances" (Bakhtin, 1986, p. 61) that relate to encounters between people, while secondary speech genres are generally mediated by texts. All areas of human activity involve language that originates in distinct spheres of human activity (Smith, 2014). Bakhtin states:

Secondary (complex) speech genres ... arise in more complex and comparatively highly developed and organised cultural communication ... that is artistic, scientific, socio-political, and so on. During the process of their formation, they absorb and digest various primary (simple) genres that have taken form in unmediated speech communion... They lose their immediate relation to actual reality and to the real utterances of others. (Bakhtin, 1986, p. 62)

Secondary speech genres then take up the experiences of people in the social world, turning them into objective and authoritative texts, creating what Smith calls the ruling relations. For example, research on chronic illness, has created a range of texts and discourses about particular characteristics of people, such as for those with type two diabetes. However, these secondary speech genres, or authoritative texts lose sight of the lived experience of the individual, and of their actual reality.

Bakhtin calls authoritative texts monologic (Bakhtin, 1986). A monologic text is considered a truth that is constructed abstractly and systematically from the dominant perspective. Authoritative texts then coordinate people's subjectivities. For example, certain texts and historical processes have favoured and perpetuated medical practitioners as the clinical leaders of health provision, and the first point of contact for patients in need of health care in the community. This dominant text then coordinates our subjectivities where, without questioning, we seek help from medical practitioners when we are unwell. Further, the dominant text of the medical professionals tells us that for each symptom there is a diagnosis, and therefore a treatment. As raised earlier, Illich named this "diagnostic imperialism" (Illich, 1976, p. 76).

Bakhtin (1986) notes that when monologic texts predominate, dialogue can be closed off, reducing opportunities for identifying and acknowledging differences. He argues that a fully dialogical social world is made up of multiple voices, perspectives, and subjective worlds, terming this heteroglossia (Robinson, 2011). There is great diversity in people's existences, yet authoritative texts can subordinate people's actualities and their lived experiences. The experiences of people with chronic illness show that through the domination of the biomedical model and diagnostic imperialism, their lived experiences are excluded, devalued, or silenced (Galvin, 2002; Martin & Peterson, 2009; Telford, Kralik, & Koch, 2006).

Smith utilised Bakhtin's notion of speech genres to explain how the social sciences categorised the experiences of people by creating objectified knowledge that in turn

dismissed and supplanted the actualities of their lives. Such monologic (or hegemonic) discourse in turn removes the rights of consciousness, suppressing and displacing the essential dialogic of the social (Smith, 2014). Throughout the health services, there are examples of the suppression of individual's dialogic engagement in the social, in which they are living their lives.

Speech genres carry particular social values, worldviews and intentionalities (Robinson, 2011). They have particular language uses and language forms, including terminology, syntax, and styles that "carry and regenerate" the social organisation of groups, institutions, discourse, "and indeed all forms of social life in which people together are concerting their activities" (Smith, 2014, p. 231). What becomes clear is how the ruling relations coordinate the social world, and in turn are reaffirmed, perpetuated, perhaps enhanced or altered, and occasionally rejected. Competing dominant discourses or monologisms are exposed to the possibilities of being deposed by contemporary heteroglossia, through the voices and standpoints of others (Smith, 2014). But the elevation of a particular hegemonic language, such as medicine, suppresses the heteroglossia of the multitude of speech genres present in the social world. It is here that the opportunity to find solutions to social problems is lost.

Smith (2005) utilised the work of Harold Garfinkel who developed ethnomethodology in the 1940s and 1950s (Rawls, 2008). In an interview with William Carroll (2010), Smith stated:

At the time, I think that ethnomethodology was quite a challenge to the hegemony of positivism and of the notion of a total, generalizing sociology: abstract formulations, good-for-all-time approaches to sociology. (p. 17)

Ethnomethodology explores how taken for granted forms of language formulate social norms and formal or theoretical accounts of the structure of society (de Montigny, 2017). The discourse of medicine and biomedical knowledge is taken for granted as having held a privileged position in health and society for over a century (Group & Roberts, 2001). While

in some rural and underserved areas, NPs have taken the opportunity to deliver services, the patriarchal language of medicine has dominated the discussion for the wider implementation of NP services in primary health care (McMurray, 2011). Similarly, the taken for granted forms of biomedical health care provision have reduced the opportunity for local people, including indigenous people, to be a part of community development and health (Khoury, 2015). Smith (2005) utilises the notion of taken for granted institutional knowledge and discourse that coordinates our everyday activities, often outside of our awareness.

Different speech genres, such as institutional and professional discourses, use various language forms and terms differently. Bakhtin describes the necessity of what I colloquially would call “speaking their language”:

Many people who have an excellent command of a language often feel quite helpless in certain spheres of communication precisely because they do not have a practical command of the generic forms used in the given spheres.... The better our command of genres, the more freely we employ them, the more fully and clearly we reveal our own individuality. (Bakhtin, 1986, p. 80)

Smith (2014) states, “[h]ere is the familiar feeling that you have when you are new to a socially organised setting, of not knowing quite how to speak” (p. 230). Darville uses the term “organisational literacy” (p. 251) to describe how we appropriately develop our language to communicate discursively (Darville, 1995). There is a growing body of health research that identifies the necessity of individuals and their families/whānau to be able to navigate their way through health systems. Not only do the patients of our systems need organisational literacy, they also require health literacy (N. R. Hughes, 2017; Martinez-Donate et al., 2013). Nursing research has often focused on the doctor-nurse relationship, nursing’s position in the hierarchy of health, and the perpetuation of nursing silence within the institutional regimes (Buresh & Gordon, 2013). Being able to use and participate in

institutional discourse appropriately enables our individuality and reduces the coordination of our subjectivities by the institutional regimes.

Smith also drew on the work of Vološinov (1973) who explored how language creates an “interindividual territory” (p. 12) always in a social situation. Vološinov described language as a two-sided act. Language is a product of the relationship between the speaker and hearer, both bringing their own consciousness to the conversation. While the writer or speaker may intend specific meaning, the reader or hearer brings their own knowledge of the social world and their subjectivities to that text. Individual consciousness, or subjectivities, are socially organised textually, and by ideology and discourse. Vološinov argued that it was through interaction with others that meaning was given to ideological signs:

Every ideological sign is not only a reflection, a shadow, of reality, but is also itself a material segment of that very reality. Every phenomenon functioning as an ideological sign has some kind of material embodiment. (Vološinov, 1973, p. 11).

As we engage with, and enact those texts or signs, we give meaning to them. In the interindividual territory people draw the text into a particular social situation and engage with the text.

People are socially organised through their reading, hearing, or seeing, (even smelling or touching), and engagement with the text. An individual activates a text in a local setting as a way of sense-making (McCoy, 1995). Smith states:

Reading a text is a special kind of conversation in which the reader plays both parts. She or he “activates” the text (McCoy, 1995) – though probably never quite as its maker intended – and at the same time, she or he is responding to it or taking it up in some way. Its activation by the reader inserts the text’s message into the local setting and the sequence of action into which it is read. (Smith, 2005, p. 105)

She terms this the “text-reader conversation” (Smith, 2005, p. 167). The notion of the text being “active” (p. 167), or the materiality of the text, is central to institutional ethnography and the process of inquiry. As the reader engages in a dialogue, the text is organising their consciousness and at the same time is “bringing the text into dialogue with where she, the reader, is and what she is connecting it [the text] up with” (Smith, 2014, p. 225). The reader is connecting with, or being hooked up into, the relations of ruling, and through her actions takes up the conceptual frames that are circulating, so participating in the ongoing ruling relations (DeVault & McCoy, 2012).

For example, Lane, McCoy and Ewashen (2010), explored the textual organisation of how older adults with mental illness were placed into long-term care. The centralised software system for placing older adults into long-term care beds was itself governed by resource utilisation, including the need to move patients quickly out of acute care, to unblock beds, and to reduce length of stay statistics. The system created a large pool of virtual and largely undifferentiated beds, while the transition coordinator created a “placeable person” (p. 3). Both the administrators from the facilities and the transition coordinator were hooked into and organised by the ruling relations. Through this textually-mediated process, the lived experience and knowledge of the older person with a mental illness became invisible.

Text mediated ruling is an exercise of power using authoritative texts to control the social world. However, texts and discourses assume, and are afforded, different levels of power within the social world, at times conflicting with others. This becomes what Smith describes as intertextual hierarchy (Smith, 1990b; 1999). Regulatory texts, or boss texts, are positioned hierarchically at the top, such as legislation and policy. Boss texts are created and authorised through institutional processes, instructing people on what to do, how to act, or how to carry out specific practices (Bisaillon, 2012). Within health services, the introduction of New Public Management, within a neoliberal policy framework, has resulted in computer technologies increasingly organising the work of clinicians within the drive to

improve efficiency and health service utilisation, and control spending (Griffith & Smith, 2014b).

Rankin and Campbell (2006), who were introduced earlier, used IE to explore the work of nurses within the managerial discourse of New Public Management. From the standpoint of nurses, the researchers explored how the admission, discharge, and transfer (ADT) software organised their work. Organisationally, the priority was to manage bed use and reduce spare capacity to effectively utilise the funding available, essentially, to control patient turnover. Ultimately, the ADT software system became the most powerful ruling text in the nurses' world. The software was enacted by the nurses, which at times resulted in patients being discharged before they were stabilised or family support was adequately in place. The ADT software as a text was able to distort or even supersede nurses' professional judgement. Professional knowledge, regarding the care of patients, the ethics of care, of nursing's knowledge, were devalued in the presence of the powerful managerial text.

Intertextual hierarchy describes the power one text may have over another within a particular local setting (Smith, 1990b). However, there may be multiple texts operating and concerting to organise the person's experiences. Based upon her doctoral work, Ruth Lowndes explored how diabetes care was organised for people with a serious mental illness living in a community home (Lowndes, Angus, & Peter, 2013). The home care guidelines stipulated the need for staff to encourage participation in health promotion activities and programmes. Within the same guidelines there were government-mandated requirements which focused on safety, cleanliness, and resident's basic needs. These latter texts were afforded greater power by the staff than those promoting activities. Lowndes et al. concluded that the numerous texts, as social forces, combined to create "multifaceted barriers and constraints" (p. 224) to the prevention and management of diabetes.

Using the notion of boss texts and intertextual hierarchy, Clune (2011), in her doctoral thesis, explicated the ruling relations of nurses required to return to work early following a

workplace accident. The boss text, in this case the Ontario Workplace Safety and Insurance Act 1997, provided a “means for controlling the return to work process across multiple worksites in Ontario” (Clune, 2011, p. 117). From this text, an injury management approach was implemented in Ontario, which in turn gave rise to various guidelines, forms, advice, and discourse. The rigid and controlling institutional processes reduced the ability of nurses to participate in their return to work, negatively affecting their successful return. The institutional opportunity was lost for injured nurses to return to the workforce in creative or new roles that could utilise their knowledge and skills.

Texts may compete with each other or have unintended consequences. Ellen Pence, a world-renowned activist feminist in the field of domestic violence and battered women, used IE to explicate how state regulated practices and procedures implemented by the criminal and justice systems conversely reduced the likelihood of victim safety as a central outcome (Pence, 2001). In later work, on indigenous women experiencing domestic violence, Wilson and Pence state:

To the ‘system’ she may be a medical case, a police case, a divorce case, a civil protection order case, a child protection case, a chemical dependency case, a welfare case, a mental health case. So there could be eight different agencies operating in a woman’s life.... Each interchange is assigned a specialist, which leaves a woman with many different people charged to ensure that a step in the process is carried out in a prescribed institutional manner.... The process is ... coordinated, not by a person, but a file – a collection of texts that acts almost as an active person in the process. (2006, p. 208)

The specialists, or practitioners, from the various agencies will each have their own set of institutional processes, including forms, guidelines, and protocols, based upon each of their professions’ authoritative knowledge, which governs their actions. The result was a

complex system of interacting texts that ultimately did not address the needs or safety of the indigenous women.

Authoritative texts and discourses form the complex web of ruling relations in the social world (Bisaillon, 2012). The replicability of texts in contemporary society enables the ruling relations to organise the everyday world of people located across time and distance in multiple local settings. Returning to the purpose of my inquiry, IE provides a way of understanding how the development of NPs in New Zealand is bound up in the wider context of social relations and ruling. Historically, the nursing profession has experienced times of advancement and times of struggle depending on political ideology and economy, and the institutional power of the professions. There are multiple texts and discourses circulating in relation to health, nursing, medicine, policy, regulation, and management, all of which may be organising and coordinating the everyday lives and experiences of the nurses and NPs. Institutional ethnography offers a way of understanding their experiences.

### **Institutional ethnography: A materialist-feminist inquiry**

A materialist-feminist inquiry is an empirical inquiry that begins from, and ends with, the lived experiences and actions of people in their local setting. Instead of using a positivist approach to inquiry, creating authoritative and objective knowledge, Smith argued that we should always work from the empirical world, from where people are situated in their local and particular settings (Smith, 1990b). Given that our education and professional training is grounded in theory, it is too easy to lose sight of people's experiences in the local setting and return to theoretical knowledge. Smith states:

There must be different experiences of the world and different bases of experience. We must not do away with them by taking advantage of our privileged speaking to construct a sociological version that we then impose upon them as their reality. We may not rewrite the other's world or impose

upon it a conceptual framework that extracts from it what fits with ours.  
Their reality, their varieties of experience, must be an unconditional datum.  
It is the place from which inquiry begins. (Smith, 1990a, p. 25)

In order to work empirically, it is necessary to relate and return to the lived experiences of people in the actuality of their lives.

### **Feminist epistemology**

Smith's work is grounded in feminism (Smith, 1974b, 1987), though she formally renamed IE as a sociology for people in 2005 (Smith, 2005). Through the civil rights movements women discovered that they had in various ways been silenced, without authority or voice (Smith, 1987). Various feminist standpoint epistemologies developed through this period. Instead of seeking to produce knowledge by objective observation where the researcher remains outside the others' experience, knowledge should be socially situated. Knowledge should begin from the lived experiences of people, and explore how the institutions, including legal, legislative, economic, educational, welfare, and health, govern their everyday lives (Harding & Norberg, 2005). Smith, as with other feminists, was rejecting the patriarchy of mainstream social science. She stated that the social sciences were complicit in the exercise of power to control relations, including between men and women, black and white, heterosexual and homosexual, and so on. She called this the *Conceptual Practices of Power* (Smith, 1990a).

However, when we begin an inquiry from the actualities of people's lives, opportunities for finding solutions to problems encountered in the social world become possible. For example, Deveau (2011) in his work on people with disabilities states:

'Unlike studies ... *about* persons with disabilities in the workplace, my study is for persons with disabilities, so that they and their allies can gain a thorough understanding of how the material conditions they encounter in their everyday lives are operating for someone else's benefit. It is only with

that type of knowledge that we can inform our praxis, and work towards ending the ongoing discrimination against us in the workplace'. (p. 154)

Through the explication of the ruling relations the possibility of deposing the dominant discourses becomes a reality, such as those constructing the subjectivities of people with disabilities.

Smith (2005) identified that IE applied equally to all people who were excluded or marginalised in some way and struggling within their social world. Institutional ethnographic inquiry was expanded to include both the gendered relations of ruling, as well as other organised forms of ruling, including class, race and ethnicity. Gender, class, race and ethnicity, are not treated in IE as external determinants, but are considered as social relations that organise people's experiences, often resulting in inequalities. The purpose of IE remains clear that it is to produce knowledge *for* people, and not knowledge *of* people, by constructing meaningful inquiry where the answers "fit the contours" of the people's lives (DeVault, 1999, p. 23).

### **Materiality**

The materiality of the social world is grounded in the happenings and doings of people. IE is situated within a constructivist paradigm where the social world is continuously produced and shaped by people. Similarly, other social scientists, such as Bruno Latour (1993) describe how technologies and artefacts, or 'things', are invested with meaning and interpreted by people in their local situation, shaping their decisions and actions. Latour aimed to overcome the detachment of the object world, where things function according to the laws of nature, from the "social world that is ruled by meaning, culture and people" (van Hout, Pols, & Willems, 2015, p. 1208). Latour's interest was in showing how particular technologies were materialised by people engaging with them. For example, Pols and Willems (2011) evaluated telecare, and found that the same technology was used differently and "tinkered with" (p. 484) by the users, in this case people with chronic lung conditions.

In turn, this affected health care practices. The researchers described the engagement of the users with telecare as the “taming and unleashing” of the technologies.

Taking a materialist framework allows the institutional ethnographer to look for socially organised connections between the ruling relations, including texts and technologies, and what is actually happening in the local situation with local people (Campbell & Gregor, 2004). Explicating these connections as materially existing shows how the ruling relations are enacted in local settings and play out powerfully in the lives of individuals in the local situation (Campbell & Gregor, 2004). Smith, as did Vološinov (1973), drew strongly on Marx and Engels’ ideas of materiality (Smith, 1990a). As a materialist inquiry, the study begins from the experience and activities of the individual in their local setting.

Experience is not the same as perspective (Smith, 1990a). Neither is a materialist inquiry about our “inner explorations” (p. 23) of an experience, because, such subjectivist interpretations are themselves an aspect of the ruling organisation of consciousness. Rather experience is the actual actions, activities, happenings, and doings of people in their local situation. In IE, this is often termed work<sup>25</sup>. An inquiry begins from people’s everyday work and actual activities, as they are happening in the material world, within their local setting. Returning to the ontological position of IE, the ruling relations are coordinating textually people’s actions and experiences. Materiality, then, is the enactment of texts by real or embodied people in their actual social world. Key to an IE is knowing the material aspects of people’s lives, what they actually do, and not what their theoretical or ideological knowledge is.

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<sup>25</sup> Work was defined in chapter one. it can “include anything that people do that takes time, effort, and intent” (Smith, 2005, p. 225).

## Exploring the ruling relations

The analytic goal of institutional ethnographers is to discover and explicate the social organisation of people's everyday lives textually and institutionally through the ruling relations (Campbell, 2014). Institutional ethnographies are concerned in some way with understanding and explicating the struggles that people encounter in their social world. For example, George W. Smith (1995), and Eric Mykhalovskiy and Lisa McCoy (Mykhalovskiy, 2001; Mykhalovskiy & McCoy, 2002), used IE to explore the ruling relations of people living with HIV/AIDs; Jean Louis Deveau (2008b, 2011) was concerned with people's experiences of living with disability; Ellen Pence and Martha McMahon (Pence, 2001; Pence & McMahon, 2003) on women's experience of domestic violence, including through the justice system; and, Ruth Lowndes (Lowndes et al., 2013) on people who were mentally ill and living with diabetes. Institutional ethnography has also been used to explore how people's work practices are organised, such as in health and social work. For example, Gerard de Montigny (1995, 2011) on social work practice; Timothy Diamond (1992) on the institutional work undertaken by residents and health care assistants; Jennifer Flad (Flad, 2003) on social work practices with people who are terminally ill; Karen Melon and colleagues (Melon, White, & Rankin, 2013) on how managerial targets and assessment scales controlled work in the emergency department; Louise Folkmann and Janet Rankin (Folkmann & Rankin, 2010) on the organisation of nurses' medication work; and Janet Rankin and Marie Campbell both together and separately on various aspects of nursing work (for example, Campbell, 2001; Rankin, 2003; Rankin & Campbell, 2006).

From the actualities of the person's experience the inquiry and analysis then moves beyond the local setting to explore the extra-local or institutional layers. Campbell (2014) describes:

Our analysis goes beyond the experiential account of the actualities that our informants have given us. We must cross analytically, not a "gap" ..., but rather the boundaries of people's experiential knowing... [W]e exploit [the]

conception of social organisation, methodologically, to track the (often textual) features of the enacted social world. (p. 1498)

The starting point or entry to further exploration is often derived from where a *disjuncture* exists between the authoritative knowledge and institutional process, and the actualities of a person's experience. In essence, the disjuncture is created between two different ways of knowing the social world - between the embodied experiential way of knowing and the ideological or conceptual way of knowing (Campbell & Gregor, 2004). Smith described this as a "line of fault" (Smith, 1987). For example, Flad (2003), in her doctoral thesis, explored the advocating work that social workers undertook with patients with a serious or terminal diagnosis, and their families. She found that there was a disjuncture between the type of work social workers wanted to be doing, including advocating for their patients, and their "institutional and textual obligations, creating a strain as they try to navigate around these protocols" (p. 158). The embodied experience was described as a "strain" on the social workers. Further, Flad is describing the work the social workers had to do to "navigate" their way around the texts. From this place, Flad began to explore the texts organising their practice.

Smith's (2005) entry into developing IE was as she experienced a tension and dissonance between her work as a sociologist and her lived experience as a single parent and working mother. As a social scientist, she was working in an institution producing objectified and authoritative knowledge, yet as a single parent she recognised how her own lived experiences were excluded. She described this as bifurcated consciousness - the disjuncture between her embodied knowing and authoritative knowing. With her colleague, Alison Griffith (Griffith & Smith, 1987), they explored how their family life as working single mothers was socially organised by the school. For the school to maintain institutional order, parents (and at that time, usually mothers) were required to undertake certain activities to be accomplished at home, such as homework, providing resources, food, adequate rest and sleep, clothing, and attending school functions. Where children did not meet school

expectations, mothers experienced feelings such as guilt and anxiety. The mother and teacher scrutinised the mother's mothering practices to determine what was wrong. The mother experienced feeling incompetent, yet using IE, Griffith and Smith could identify mothering as a work process institutionally coordinated by the education system and educational discourse.

Disjunctures may be experienced as tensions, contradictions, frustrations, stress, anxiety, and so on. The disjuncture can be used as a place that *opens the door* to further exploration of the ruling relations (Deveau, 2008a). Rankin and Campbell (2009) explored how health information technology and health services research has generated objectified, authoritative knowledge which is being used to reform the health care system with the promise of ongoing improvements. From observing and talking with nurses they found:

At each turn of nursing activity the nurses relied on knowledge from a care pathway – as opposed to relying on what they know as knowledgeable actors, embodied and embedded in a professional domain. (Rankin & Campbell, 2009, p. 15)

The nurses described how their nursing work “chafed”. They were describing their bifurcated consciousness of living in two worlds. In their embodied world, they knew about nursing and how to do it. They had tacit and experiential knowledge of how to care for their patients. But their subjectivities had been constructed by the imposition of institutional standardised processes, such as care pathways, within a New Public Management regime.

While the nurses experienced a sense of frustration and dissatisfaction about their work, they continued to enact the managerial texts controlling their nursing work, and in so doing perpetuated the ruling relations. The institutional work practices of efficiency ultimately become taken for granted. Rankin and Campbell (2006) describe how a nursing student creatively moved an eighteen-year-old mother, who had just given birth to her second child following a difficult labour and was weary, to her own room. The nursing student was

criticised by the staff and supervising instructor for not adhering to a range of texts, including equity, breaching principles of sepsis (as housekeeping would not be able to clean the bathroom for the next patient), and (for some inexplicable reason) the new maternal-child care philosophy. Ultimately, the nursing student who had acted creatively and from a caring place was guided towards an uncaring response. Rankin and Campbell stated that if the nursing student and her mentors had used alternative knowledge they might have noticed the taken for granted authoritative knowledge of the efficiency practices of the hospital.

They might be able to reclaim their experience of how this chafes, as it produces a disjuncture between their caring commitments and the inexorable unfolding of so-called hospital efficiency. It is in this disjunctive space that an analysis for oppositional work can begin for nurses, within the terrain of their practical activity. It is here where possibilities for social action can be sparked – taking up the standpoint of nurses, in the interest of their patients. (Rankin & Campbell, 2006, p. 180)

From Rankin and Campbell's research, the possibilities for IE are made visible. By explicating how the institutional texts are organising nursing's work, it gives the opportunity for nurses to join together collectively and "take back our work" (Rankin, 2009). However, when nursing work continues to perpetuate the managerial discourses of ruling, then the voice of nursing and nursing knowledge is lost to the organisation.

When nursing work is invisible in the institutional processes, there is a frequently missed opportunity to use their experiential, embodied, and tacit knowledge to improve institutional processes, patient safety, and quality of care. Elizabeth Quinlan (2009) explored the knowledge work that was undertaken by health care workers in multidisciplinary primary health care team settings. Three NPs from urban, rural, and remote rural practices in Canada were shadowed over several weeks to investigate how authoritative knowledge, including regulatory documents, health service utilisation reports

and policy documents, was transferred into individual practices. Quinlan stated that the aim of “these system-generated mandating texts is to standardise and coordinate teams” (p. 638). However, while these texts are authoritative, in that they dictate action within the practice, they can also have liberatory potential to create new knowledge.

Quinlan (2009) used evidence-based practice clinical guidelines as an example of a standardised, authoritative text that was enacted in a primary health care practice. She identified that the knowledge processes of evidence-based practice are both technical and cognitive, but do not fully account for the tacit, practice-based knowledge. This created a disjuncture and tension for the practitioners. However, there was the possibility to create and apply new practice based knowledge. Essential to this process was the collective dialogue within the multidisciplinary team about specific clinical issues. Quinlan described this as an interplay of text and dialogue. At times, the biomedical authoritative knowledge prevailed. However, at other times the collective dialogue allowed for the exchange of tacit knowledge and enabled the creation of new practice based knowledge.

## **Mapping**

“Mapping” is an analytical tool used by institutional ethnographers to show how text mediated ruling occurs (S. M. Turner, 2006, p. 139). As the inquiry proceeds, DeVault and McCoy (2012) explain the aim of the researcher is to:

[E]xplore particular corners or strands within a specific institutional complex, in ways that make visible their points of connection with other sites and courses of action and always with a focus on how they are produced through the coordinated activities of people and the consequences they carry. (p. 383)

Mapping enables the researcher to show the connections of how the work processes embedded in texts are enacted in the local setting. Fundamental to the mapping process are the text-based work sequences that show how institutional action is coordinated (S. M.

Turner, 2003). Turner mapped the municipal planning process that aimed to develop land in a ravine close to her home. She stated:

Tracking a sequence of text-based work gives us a way to not just map position locations within an institution but to make visible the power of texts to organise what is getting done and how... Institutional ethnographers ... bring into question what is commonly known, and examine the conceptual and textual work that in actual local practices bring commonly known institutional entities into existence and coordinate large-scale organisation. (S. M. Turner, 2006, p. 159)

Turner used mapping to both show what actually happened through the planning process, and how the process was mediated by the texts. Embedded in the multiple texts (legislation, policy, and directives) were a range of work processes that controlled the planning process over several years.

There are various and diverse ways of conducting an IE. DeVault and McCoy (2012) describe the “classic” approach of beginning from the everyday experience of people in a particular area, and exploring how the standpoint informants are being connected up into the ruling relations, as did Lowndes et al., 2013 (see above). Deveau (2011) explored how a person who had specific needs for air quality in an office complex was hooked into the ruling relation of disability through a local workplace policy:

Matt’s activation of a local text hooked him into higher order, or boss, texts which “somehow” transformed his problem with air quality into a biological deficiency and freed his department from having to develop a more inclusive workplace. (Deveau, 2011, p. 160)

By mapping the process, Deveau traced the actualities of Matt’s experience to the Canadian Employment Equity Act (1995), a boss text designed to protect the rights of workers and ensure people with disabilities are accommodated in the workplace. From the Act various policies and assessments were devised across different organisations involved in workplace

safety. As a consequence, Matt was not accommodated in the workplace. Deveau concluded that by using IE, he was able to show how powerful texts transformed the “experiential way of knowing disability into the ideological way of knowing it” (p. 170).

Others begin with an institutional process, and explore how the process is organising the work of the people in the local setting (DeVault & McCoy, 2012), such as Rankin & Campbell’s (2006) IE on the organisation of nurses’ work by the ADT software (see above). Folkmann and Rankin (2010) explored nurses’ medication work that has been informed by the dominant discourses of biomedicine, health care management, patient safety, and law. Technologies and procedures have been introduced to improve patient safety. However, in their IE, they found that the authoritative knowledge was different from the experiential knowledge of nurses who are ordering, dispensing and administering medication. The coordinating power of the technologies at times overrode the nurses’ knowledge around the complexity of the situation, posing greater risk to patient safety.

## **Summary**

“Discovering” IE was a very significant moment in my work as a doctoral student. In essence, the ultimate purpose of undertaking this research was to find out how we could get more NPs working in rural primary health care in New Zealand. Through my own experience, and from hearing stories from others, I was increasingly interested in the ability of a range of organisations and discourses helping or hindering nurses on their journey to becoming NPs. Institutional ethnography offered a way of understanding how their social world was constructed, and the coordinating power of the texts and discourses in circulation.

As a research approach, IE sits within a critical qualitative paradigm. Researchers using IE do so because they understand that the everyday world that people live and work in can be improved by making visible how this world is being controlled and organised by the

institutional powers, showing where the possibilities for change may lie. The intended audience of an IE includes the informants of the research, as well as others in similar localities. Making the ruling relations visible to people in their localities not only raises awareness as to how their world is textually coordinated, but also gives clues as to what is needed to change the way their social world is shaped. Additionally, the research is intended for those organisations and institutions who hold the dominant and powerful positions in society and who produce the texts which organise the everyday lives of the informants in their social world, for they may also seek change.

This chapter has provided an introduction to IE. I am aware that I may not have done Dorothy Smith's work, nor the work of other academics and researchers, adequate justice. However, I hope that there is sufficient information and insight to assist the reader in understanding my inquiry and how it has developed. There are two key purposes to an IE. The first is to show the actualities of people's everyday lives – what they are actually doing and experiencing in their social world; and the second, is to explore how they are connected up with the ruling relations and how those ruling relations – the circulating texts and discourses – are organising their everyday activities. In the next chapter, I present the methods, and the analytical approach used to map and explicate the ruling relations.

# Chapter Four

## Methods

### Introduction

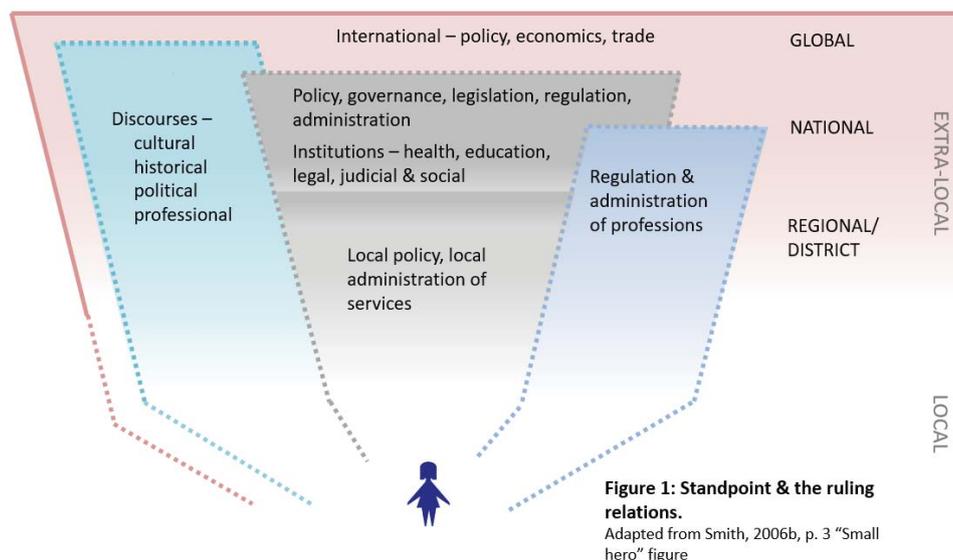
The overall purpose of this study, as previously noted, was to critically examine the work required to establish NP services in rural primary health care in New Zealand. Chapters one and two provided the background to the study, locating NPs as an effective and appropriate health workforce for delivering health services in rural New Zealand. Despite the legislative, regulatory, and educational framework in place for developing the NP workforce, the growth in NPs authorised and delivering health services has been slow to develop. The following interrelated research questions guided the framework and approach to the study:

- How do nurses and NPs describe their experience of becoming a NP, gaining employment, and delivering NP services in rural New Zealand?
- How is their experience textually shaped and organised in their local settings?
- How are institutional texts and discourses coordinating and controlling the development of the NP workforce in New Zealand?

Institutional ethnography provided the ontological and epistemological approach, as discussed in chapter three. In this chapter, I describe the strategies used to undertake the study, the location and engagement with the informants, through to data collection and analysis. I also refer to a paper published by SAGE as a research methods case study (Adams & Carryer, 2017, see Appendix C), which focussed on research ethics, the methods of IE, and using IE to explore the institutional work of ethics committees.

## Institutional ethnography: A methodological framework

Institutional ethnographies make connections between the standpoint of the people and the work they do in their particular locality and the organisational ruling. The material and concrete experiences of individuals are key to discovering how the localised social world is organised and shaped extra-locally, or externally, to that local world (Smith, 2005). These informants are the active subjects and knowers of their everyday worlds (Grahame, 1998). The study began from my experiences, and it is further from the standpoint of the primary informants, NPs and NP candidates<sup>26</sup>, that the inquiry grows. In chapter one I included a figure (Figure 1, p. 14) depicting how the ‘small hero’ in the local setting is looking up into the mass of ruling relations. Drawing from her early IE exploring mothering as a single parent (Griffith & Smith, 1987), Smith described that an IE starts from the standpoint of that person, a “small heroic figure standing there, at the bottom, peering into the ruling relations that tower above her” (Smith, 2006b, p. 5). The individual becomes hooked up into the institutional ruling relations that organise their work and experiences. I show it here again for ease:



<sup>26</sup> Nurse practitioner candidates are those RNs intending to become NPs and are either completing, or have completed, their final paper for their clinical Master’s in Nursing, but are yet to submit their portfolio of advanced practice nursing to the Nursing Council for assessment.

The ruling relations occupy the extra-local territory. Here I have shown some of the types of texts and discourses that ultimately coordinate the nurse's daily work in practice and in her journey to become a NP. Data is collected from the local situation, using ethnographic methods, which for this study was primarily interviewing, with some additional textual material. During the interview the researcher, in dialogue with the primary informants, is attempting to identify both the texts and discourses that are being enacted, and the disjunctures between the authoritative knowledge and the actual reality of the informants. Both researcher and participant are active in this process (DeVault & McCoy, 2012).

From a particular text or discourse, or the point of the disjuncture, contradiction, or tension, the researcher crosses the boundary from the local to the extra-local, and begins to trace the texts that entered the local setting. At the extra-local level, further data is collected, either from secondary informants or through textual analysis. Importantly, the purpose of an IE is "not to generalise about the group of people interviewed but to find and describe social processes that have generalised effects" (DeVault & McCoy, 2012, p. 383). The challenge, as I experienced, was knowing where to begin further analysis. Multiple disjunctures, texts, and discourses became evident as I interviewed the primary informants.

At the outset of an inquiry, the researcher will not know where further data collection and analysis leads. While the researcher has identified an area of the social world in which to begin the inquiry, the direction and further focus of the study is revealed by the primary informants, usually at the point of disjuncture (Campbell & Gregor, 2004). This is called the "problematic" of the everyday world, and "arises precisely at the juncture of particular experience, with generalising and abstracted forms of social relations" (Smith, 1987, p. 157). However, as I was pursuing my inquiry, it became increasingly clear that there seemed to be several problematics, and ultimately, I have drawn on Smith's words<sup>27</sup> that the term "problematic is itself problematic". Instead, I consider that there were various places, entry

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<sup>27</sup> Workshop attended at University of Toronto, Canada (Smith & Turner, 2012)

points, or perhaps *portals*, from which to cross over into the extra-local and explore how the development of the NP workforce has been institutionally organised.

## Mapping

Smith (2005; 2006a) describes the analysis of texts as mapping. She likens the process to mapping a geographical area, where the goal of the researcher is to explore and explicate a particular section of the map. Mapping requires the identification of texts and discourses with which the individual in the local setting is engaging (often unknowingly). For my inquiry, firstly, I began from the experiences of the NPs and NP candidates, mapping their connections with texts and discourses, and identifying disjunctures; and, secondly, I traced the texts that demonstrated the ruling relations further into the institutional layers.

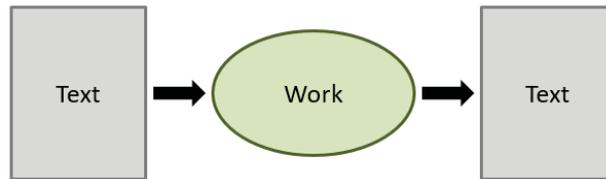
The process of visually mapping interviews was a key analytic method that I used in this inquiry. From the maps of the primary informant interviews, I identified particular entry points of tension, conflict, or difference to further explore the ruling relations, as well as seeking to identify texts that positively coordinated their work to be a NP. Additional data was gathered from other informants in the local situation, such as general practitioners and practice managers, and extra-local informants; and textual data was acquired from a range of sources, including academic literature, policy, strategies, legislation, historical documentation, popular nursing and medical press, as well as written communication within and between organisations.

To illustrate how the text-based work processes are embedded in documents, I use my analysis of the Nursing Council (2002, updated 2011) document *Nurse Practitioner Scope of Practice: Guidelines for Applicants*. In 2012, I attended a workshop in Canada with Susan Turner<sup>28</sup>, and mapped the 2011 document using text-work-text sequences (Smith, 2006a).

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<sup>28</sup> Workshop attended at University of Toronto, Canada (D. E. Smith & Turner, 2012)

Texts are marked with a rectangle and work or actions with a circle, as shown below:



I began the mapping from the time the NP candidates applied to the Nursing Council. The document provided the details of the actual processes laid down by the Nursing Council. This is the authoritative version of how the process unfolds. By doing this, the *expected* work that is undertaken by both the NPs and various employees of the Nursing Council is shown, and this is, in itself, substantial. The map could potentially then be used as a reference point from which to explore NPs' actual experiences of the application and assessment, to show how the institutional processes both coordinate their work and create a disjuncture between what should happen and what actually does happen. The map is shown on the opposite page (p. 109).

Ultimately, I decided not to include the data from the primary informants of the experiences of the NP application process due to the changes to both NP scope of practice and application and assessment process from 2017 (Nursing Council of New Zealand, 2017c). The primary informants revealed through the interviews that they believed the application process was improving due to improved knowledge of the process by applicants, improved mentoring, and the Nursing Council's ongoing efforts to improve the process. However, methodologically, this mapping exercise was a significant point in the development of my research approach.

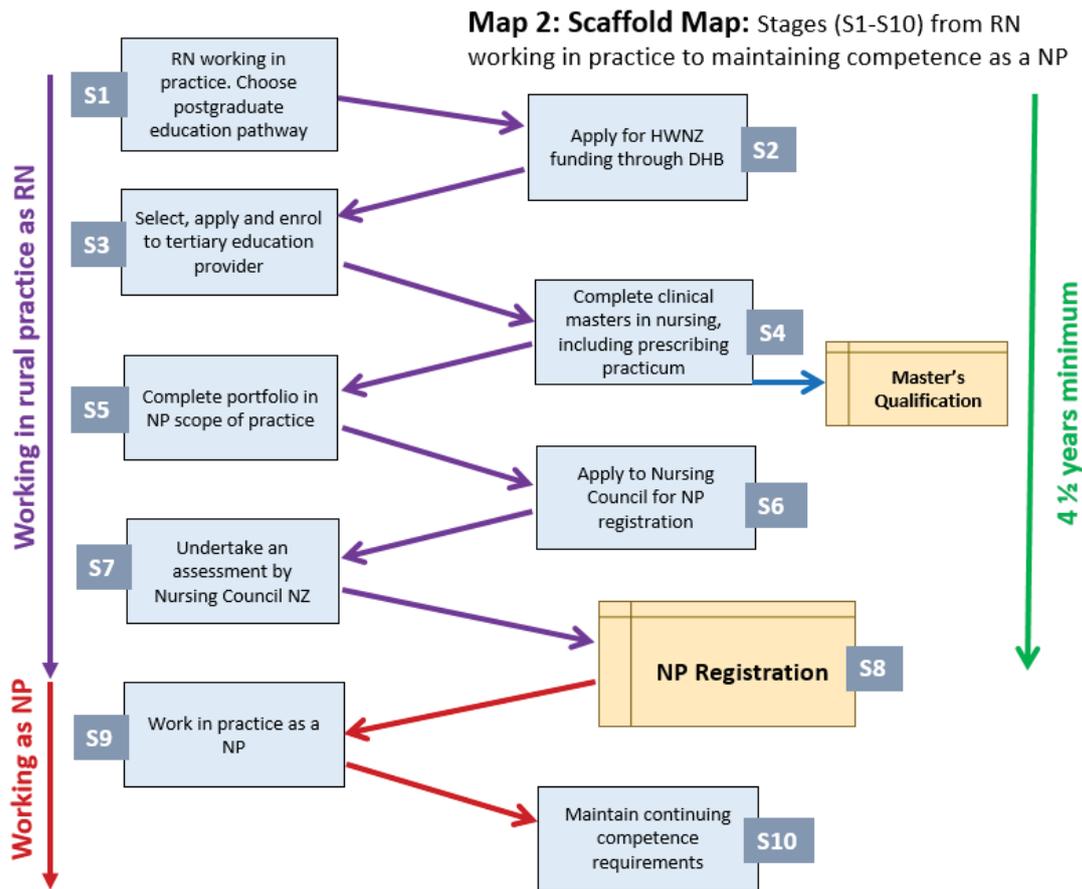


Laurel Clune (2011), in her doctoral thesis, critically examined the return to work processes of nurses injured while at work. Clune used mapping to show how the nurses' experiences and activities were socially organised by a range of powerful texts. In her thesis, she pictorially drew maps of each nurse's progress from the time of the injury to return to work (or not). In order to depict the journey, as it should have been according to the authoritative knowledge available, Clune developed, what she called, a *scaffold map*. The scaffold map showed the expected process for nurses returning to work – the prescribed pathway – that she identified through legislative and policy texts. Against the scaffold map, Clune mapped the actual experiences of the nurses. From the maps, Clune managed to trace the discourses and texts revealing the complexity of the ruling relations organising the process of nurses returning to work following injury. This analytical framework appeared to provide me with the approach I needed to use to discover answers to the research questions.

In 2012, I began by drawing out the process using the authoritative knowledge provided through documentation from the websites of the Nursing Council, Health Workforce New Zealand, various tertiary education institutes, College of Nurses Aotearoa, and New Zealand Nurses Organisation (see Appendix E). From this, I developed a scaffold map (see the opposite page, p. 111) of the journey registered nurses (RNs) would follow to become an authorised NP working in practice<sup>29</sup>. The stages have been labelled one to ten (S1 to S10). The minimum timeframe of four and a half years is based upon nurses completing 60 credits per year throughout the master's programme, and then completing the application process to the Nursing Council to be authorised as a NP. However, in reality, the length of time taken for nurses to move from enrolling in a clinical nursing masters to registering as a NP varies enormously.

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<sup>29</sup> Exceptions may be for those nurses from overseas with an existing master's qualification who would apply to Nursing Council to demonstrate equivalent qualification/experience who could enter at S4; some nurses might also self-fund (S2)



Smith (2005) described IE as being analogous to the process of creating a map of a particular territory of the social world. Further, she used the analogy of placing a magnifying glass over a certain section of the map. Throughout the findings chapters I refer back to the scaffold map to show the extent of the text-based work processes involved at the various stages. Additionally, I have also used the maps to show the various texts that are being enacted, and the points of disjuncture. I describe further details of the analysis later in this chapter.

## Standpoint and social location of researcher

The researcher in an IE is required to take up the standpoint of the primary informants, and from their knowledge of their experiences and activities to then explore the text mediated ruling of their social world. The primary informants represent a location in the social world where they are in some way marginalised by organisational and institutional power

(DeVault, 1999). My entry point to this inquiry was as a nurse who had wanted to become a NP while working in primary health care. Yet the process of becoming a NP, as I had envisioned it, was not my reality.

I entered this inquiry from the knowledge, and my beliefs, that NPs were a solution to ongoing primary health care workforce issues, ongoing inequalities, the ageing of the population, and the growing prevalence of chronic illness. I had experienced that my nursing knowledge was marginalised and under-valued within a health system that continued to support the biomedical model of general practitioner-led primary health care. I had no intention of usurping the contribution of the general practitioner, but did believe that I (as do NPs) offered an alternative model of care that effectively supported those patients, whānau, and communities with complex health needs. I was frustrated by the many barriers I encountered at various places on my journey.

However, because of my potentially similar experiences to the primary informants, I had to be particularly careful that I didn't make assumptions about their work and actualities. Smith calls this "institutional capture" (Smith, 2005, p. 119) where the informant uses institutional language, and the interviewer risks filling those institutional concepts from their own position of having authoritative knowledge (DeVault & McCoy, 2012). A salient piece of advice I received from Dorothy Smith at the workshop in Canada (Smith & Turner, 2012) was that "if the researcher learnt nothing new from an interview that helped piece together the particular puzzle, then her job as interviewer had not been done well" (Adams & Carryer, 2017, p. 7). In other words, I had to be particularly mindful that I did not fill in the gaps of the primary informants' knowledge nor slip into contextualising their experiences. As the primary informants knew my background, it was all too easy for them to say, "You know what it is like", and for me to agree. At these places, if I wasn't careful, I could insert my own knowledge and experience rather than discovering theirs, and if I did this, I would learn nothing new. I certainly caught myself falling into the trap of empathising

and affirming at times, though as I became more experienced at interviewing, I believe I improved at following up, for example, “So tell me what you did?”; “How did that happen?”; “Where did that request/suggestion/idea come from?”; “What did you do next?”

## **The location of the study: Rural New Zealand**

I chose to locate my study within rural New Zealand, as described through chapters one and two. Further, by focusing on rural health the scope of my research was reasonably contained. Informants from a wide range of geographical and practice locations from across the country, from both North and South Islands, were included. There are multiple organisations operating in the primary health care sector in New Zealand in which NPs potentially could be employed. I was interested in those NPs who were delivering general practice services in rural areas in New Zealand, including services provided by DHBs, PHOs, community health organisations and trusts, and general practitioner-owned practices.

As discussed in chapter two, there is no adequate definition of rurality for New Zealand (Fearnley et al., 2016). Utilising the New Zealand classification of the urban/rural profile (Statistics New Zealand, n.d.-b), locations in this study included independent urban areas, and those rural areas with moderate or low urban influence, and highly/remote areas. In their discussion on the urban/rural profile, Statistics New Zealand (n.d.-b) state:

Communities that are rurally focused tend to be further from urban centres, particularly main urban centres, and have poorer access to services. Health services are seen as a crucial resource that is lacking in many rural areas.

The PHO Services Agreement<sup>30</sup> further defined rural areas as having a population of less than 15,000 and where hospital services were at least 30 minutes away by road from the

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<sup>30</sup> See PHO Services Agreement Version 4, July 2016. <https://centraltas.co.nz/assets/Planning-and-Collaboration/Primary-Care/Agreements-and-Protocols/PHO-Services-Agreement-Version-4-1-July-2016.pdf>

place of work of the NP (as defined in the PHO). For the purposes of this research, I utilised this definition, and included those rural areas with limited access to local health services.

## **The informants**

All the individuals who participated in the study were considered expert knowers in their everyday experiences, whether in the local or extra-local setting. The term *informants*, is generally used by institutional ethnographers, rather than sample, to indicate that the focus of the study is on the organisational processes, and not the individuals (DeVault & McCoy, 2012). The primary informants are those in the local setting, in this case the NPs and NP candidates, while the secondary informants are those who have institutional knowledge. Table 1, on the following page (p. 115) describes the occupation of the informants.

### **Primary informants: Nurse practitioner candidates and nurse practitioners**

A total of eight NPs were interviewed individually as primary informants, and four NP candidates. Additionally, I met with a group of NPs on two occasions, first in 2014 and secondly in 2016. The first group also included four nurse leaders of the PHO and DHB. Three of the NPs individually interviewed also attended the groups. A further five NPs were present at the group interviews. In total thirteen NPs and four NP candidates participated as primary informants.

All the primary informants were female, and five identified as Māori (NPs or NP candidates). The NPs had been registered between twelve months and eight years as prescribing NPs. The NP candidates had either completed their master's, or were completing their final master's paper. The primary informants were employed by a variety of health care providers delivering health services in rural areas. The providers included general practice clinics, a trust owned general practice health clinic, PHOs, Māori health providers, and DHB funded clinics. The primary informants worked in areas across New Zealand in both north and south islands, and came from a total of six different DHBs.

**Table 1: Primary and secondary informants and occupation/role**

<b>Primary Informants</b>	<b>Secondary Informants</b>
<b>Individual Interview = 12</b>	<b>Individual Interview = 11</b>
Nurse practitioners (8)* Nurse practitioner candidates (4)	General practitioners (2) Practice managers (3) Nurse leader PHO Director of Nursing (2) Chief Medical Officer Planning and Funding manager Deputy Chief Executive (New Zealand Rural general practitioner network)
<b>Primary Informants</b>	<b>Secondary Informants</b>
<b>Group Discussions</b>	<b>Group Discussions</b>
Nurse practitioners (8)* and nurse leaders (4) in 2014 Nurse practitioners (revisited) (7)* in 2016 *(Two of the NPs participating in the group discussions also were individually interviewed)	Leadership group: Chief Executive Officer PHO Associate DoN – primary health care Nurse leader PHO General practitioner forum (20+) Senior medical officer forum (20+)

### **Secondary informants**

Secondary informants provide institutional knowledge arising from the primary informants' experiences, with the intention of exploring how the local experiences have been textually organised. The secondary informants came from a range of institutional settings. In addition to several individual interviews, I had the opportunity to attend two group discussions with a general practitioner forum and a senior medical officer forum, led by a senior academic to discuss the development and potential of the NP workforce. The data from these forums particularly provided information on the ongoing institutional discourse and experiences of the doctors.

## Overview of the study's process

Institutional ethnography is an empirical, qualitative approach to inquiry that intends to connect the organisational ruling with the experiences and activities of the primary informants. The approach is open-ended in order that the researcher can pursue lines of further inquiry as they arise from the data collection process. The analysis is an “inductive and iterative process” (Bisaillon & Rankin, 2013, p. 4) beginning from the first interview and continuing through to the writing-up of the results.

The research process then, is a gradual mapping of a specific area, building up the pieces bit by bit. Smith (2005) states that our methods for proceeding through an inquiry are not only guided by the original concerns of the study:

[B]ut more important[ly], they are guided by the interlocking character of work knowledges of people differently located in a process. In a sense, different pieces of the puzzle select other pieces and select those aspects of other work knowledges that fit. It is as if it were a jigsaw puzzle that grows piece by piece into its own direction. (p. 159)

My research process has been iterative, and, I think it would be prudent to admit, at times messy, though in part this was what drew me to IE. Our social world as we know it is messy and complex. Endeavouring to unravel how the organisation of the development of the NP workforce happens, within a complex of multiple organisations and discourses, is challenging. Below I have identified the key stages and processes of the research, which are described through the remainder of the chapter.

- Ethical review process
- Cultural safety and the Treaty of Waitangi
- Selection of primary informants
- Informed consent
- Confidentiality and anonymity

- Primary informant interviews and mapping
- Textual analysis and secondary informants
- Credibility and rigour
- Presentation of findings

## **Ethical review process**

The study underwent a full ethical review and approval was given by the Massey University Human Ethics Committee: Northern, at its meeting held on 23 August 2012. Application reference: MUHECN 12/062. (See Appendix F)

The process of completing the ethics application itself became of great interest to me and became the topic of a case study published by SAGE (Adams & Carryer, 2017, see Appendix C). At the outset of the ethics process, I was faced by a complex and lengthy form requiring information in ways that did not appear to entirely suit an institutional ethnographic approach. Further, I was only myself just beginning to grasp the essence of IE, and while I understood the ontological position of IE (to some extent), I most certainly did not have much sense of how the research would progress within an iterative analytical framework. What I discovered was how IE became useful to me in understanding the ethics review process.

The ethics review process is an institutional authoritative process governed by texts that have developed historically in order to protect individuals, communities, and environments, while at the same time allowing exploration of the social world (Adams & Carryer, 2017). I had previous limited experience of ethical review processes both in New Zealand and in Oxford, UK, and while having a good enough knowledge of the ethical principles, largely considered the review process as one to get through in a timely way. However, by exploring my standpoint as a researcher, noticing the disjuncture I experienced between ethical

principles, the form itself, and the work I had to do, led me to explore how my experiences were being textually coordinated.

Through the published article (Adams & Carryer, 2017), the texts that have governed the development of the ethics review processes across the world were highlighted alongside the key ethical principles – respect for people (informed consent), beneficence, and justice. Ethics should be an ongoing and central concern in social science research, including through to writing up and publication. However, in practice, the ethics review process is a one-off event and as such poses limitations at the outset of the research, and fails to engage with the ongoing research (Hammersley, 2009; McAreavey & Muir, 2011). There are two concerns here. Firstly, that social science, particularly where it is iterative, open-ended, or in partnership with informants, can be limited by the ethics review process, restricting the opportunity to gain knowledge about the social world (Truman, 2003); and secondly, that researchers may approach the ethics review process strategically, potentially “playing the game”, and not adequately engaging with ethical principles, resulting in a risk to the trustworthiness or validity of the research (Israel, 2015; McAreavey & Muir, 2011).

By piecing together the textual organisation of the ethics review process, and a brief exploration of the tensions expressed in the literature, when using, for example IE, action research, and consumer-led research, enabled me to connect with the ethics review process as a positive learning experience:

Applying an IE approach to the research process enabled a theoretical understanding of the ruling relations of the ERP (ethics review process) which in turn translated into practical action. This is an exemplar of the very purpose of IE which is to explore how the ruling relations textually regulate and coordinate our everyday activities or work. In turn, we engage with and activate, often unconsciously, those ruling relations. Gaining insight and understanding into the ruling relations of the ERP enabled us as researchers to choose how to consciously engage with the ruling relations and the texts

which they produced. Rather than seeing the ERP as a regulatory hurdle to jump through, IE enabled us to approach this with a fuller understanding of the ERP and resultant texts. This resulted in learnings that had not been anticipated. (Adams & Carryer, 2017, p. 13)

While the ethics review process is a one-off event, it is necessary for the researcher to continue to maintain ethical reflexivity in the field (Hammersley, 2009). Bisailon (2012) stated: “It is only after the researcher is immersed in the field, and has talked with people, that the problematic necessary for investigation crystallises” (p. 618). Given the small numbers of NPs in rural New Zealand, I had to be particularly mindful as the inquiry progressed to ensure I upheld the core ethical principles of informed consent, beneficence, and justice. Particularly, I was aware of the tension I felt between protecting the NPs in the study, and the grounding of the study in reducing health inequalities and promoting social justice. It is ethically right that at certain times, things are left unsaid.

## **Cultural safety**

New Zealand is governed as a bicultural nation under the founding document, the Treaty of Waitangi, which is considered central to health service policy and research in New Zealand. All health research is considered of relevance to Māori, and the concepts of protection, participation, and partnership which are embedded in the Treaty are required to be demonstrated throughout the research process (Health Research Council, 2010; Massey University, 2015). Further, in the nursing profession, cultural competence is required to be demonstrated by the regulatory authority, the Nursing Council of New Zealand.

Cultural safety was first defined by Irihapeti Ramsden (1990) in the hope that it would enable a clearer response to health needs, particularly for those currently disadvantaged (Richardson, 2004). In nursing in New Zealand cultural safety is a critically reflective concept embodying safety, where effective nursing practice can only be declared culturally

safe by the person(s) experiencing the care (Banks & Kelly, 2015; Richardson, 2004). The purpose of cultural safety is to shift the balance of power from the professionals to the Māori individuals, their whānau, and communities. As a nurse, registered with the Nursing Council, and a researcher, I am bound to demonstrate culturally safe practice through my nursing work, including as a researcher. Central to my research was the assumption that NPs could provide services to disadvantaged, underserved groups in the population. Māori are particularly disadvantaged, as is seen in the literature on persisting health inequalities (for example: Matheson & Loring, 2011; Woodward & Blakely, 2014).

At the start of the study I approached and sought cultural advice from Te Tai Tokerau PHO in the north of New Zealand. The Chief Executive Officer (CEO) from this organisation, Rose Lightfoot, has been an important leader and mentor in growing my determination to undertake this research. Approximately 45% of enrolled patients at Te Tai Tokerau are Māori, and the PHO has been instrumental in developing NP services to this very rural and deprived population. The Associate Director of Nursing, Hemaima Tait, provided specific advice on approaching, consenting, and interviewing primary informants. Further, she guided me on how to acknowledge and respect the tikanga of the PHO, other providers, informants, and the community itself. Tikanga are guiding principles, concepts, and rules for a given context, while embracing Māori culture, values, beliefs and traditions (L. Pere & Barnes, 2009). Historically, Māori knowledge was passed orally, and knowledge that is not “retained through memory is not really yours to know” (L. Pere & Barnes, 2009, p. 456).

As a Pākehā (non Māori) researcher, and one that arrived in New Zealand in 2005, I was fully aware that it was not possible for me to grasp the tikanga of each context. To mitigate this, I drew on my experiences and knowledge of engaging with Māori through a mihi<sup>31</sup>. In essence, I introduced myself, my story of how I came to be here doing the research, a little

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<sup>31</sup> A mihi is a greeting or formal introduction. Through a mihi, people show their respect for the person or group they are meeting, and are expected to share a little of their own background – who they are and where they come from.

of my family, and how I intended to use the knowledge from the informants. I also ensured that we discussed the process of the research and how they would like it to proceed. The principles of IE as a feminist epistemology supported this process. Of course, the informants were advanced nurses and NPs, and as such were knowledgeable of social science research and its forms. The credit to the rich dialogue that ensued rests with the informants and their generosity in welcoming me into their knowledge sphere of the social world.

## **Selection of primary informants**

Primary informants were selected from across the country. While there was some methodological imperative to explore the development of the NP workforce from a single geographical area, I was aware that there appeared to be geographical differences, particularly in the success of establishing NP practice. New Zealand has a small population, yet is a geographically relatively large area. Health services and organisations have developed over time with diverse models of governance. I wanted to ensure that my study would have relevance for all of rural New Zealand, and particularly I wanted to avoid a seemingly common discourse of “It’s different for us” or “That wouldn’t work in our area”. Further, while general practitioner-owned general practice dominated, I was aware of other models of NP employment and hence wanted to explore experiences of those informants.

The informants for the interviews were all NPs or NP candidates in rural primary health care. The recruitment process began through contact with the CEO and a nurse leader at Te Tai Tokerau PHO who were willing to support the research. At the time, the enrolled population of Te Tai Tokerau PHO was approximately 43,000 people with 40% Māori ethnicity. It is considered one of the most deprived PHOs in New Zealand, and has faced a significant issue in recruiting and retaining general practitioners. Te Tai Tokerau PHO had a national profile of supporting and employing NPs within their area. From here I used a process of recruiting informants through other networks and snowballing. At the time I

started my research there were approximately one hundred NPs working across the whole health sector, and about one third in primary health care. The informants were interested to participate, share their journeys and experiences, and to discover how their experiences had been shaped institutionally. Having made initial contact with the primary informants, either by email or phone, I then followed-up with an email to introduce myself and provide information about the study.

## **Informed consent**

All the informants whether individually interviewed, or interviewed in small groups, were sent or given an information sheet (see Appendix F)<sup>32</sup>, excepting the two forums (with general practitioners and senior medical officers) who were consented verbally. Informants were followed up, and a time and place arranged for the interview. At the time of the interview, the information sheet and the study were described, and the informants asked to sign a consent form. All the primary informant interviews were audio-taped. Not all the secondary informant interviews were audio-taped, in which case notes were taken, and returned to the informants for verification. The audiotapes of the interview were transcribed, and returned to the informants unless they chose not to review the transcripts. Transcripts were returned<sup>33</sup> to the informants who were given an opportunity to revise or add to the data, and further consented for the data to be included in the study.

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<sup>32</sup> I want to note here that initially I used the term “participant” in part guided by the ethics review process, and the forms show this. In hindsight, I would change the wording to informants throughout.

<sup>33</sup> In the early stages of the research, the transcripts were not returned in a timely way. This was another learning for me in terms of managing transcribers and the process.

## Confidentiality and anonymity

Given the low numbers of NPs in New Zealand at the time, I was particularly concerned about issues of anonymity, which I explained to the primary informants. In our article (Adams & Carryer, 2017), I provided two examples where informants had particular concerns about protecting their anonymity. To endeavour to protect their anonymity, the following strategies have been incorporated in this thesis:

Use broad descriptors of the informants as a group, rather than individually, ensuring that examples of mapping and quotes cannot be identified.

Ensure representation by participants from across New Zealand and define location by district, rather than by local area.

Describe the concern regarding anonymity expressed by informants in the thesis and the decision to only use pseudonyms attached to data which does not connect the data to an identifiable location or individual. (Adams & Carryer, 2017, pp. 12-13)

Informants' details and data were stored electronically on a password protected computer at Massey University, and only accessed by myself. The audio-recordings were transferred into a MP3 file, deleted from the recorder, and stored separately from their details, and electronically using pseudonyms. Paper copies of the transcripts were kept in a locked cabinet in my office. The transcribers signed confidentiality agreements and were not given the informants details. Signed consent forms were kept in a locked cabinet in my office. Apart from the informants and the transcribers, only my first supervisor has had access to the transcripts.

## Primary informant interviews and mapping

The interview in IE is considered more as a dialogue or “talking with people” (DeVault & McCoy, 2012). The primary informants are expert knowers of their experiences and actions in their social world. However, often the authoritative and institutional ruling is obscured or invisible. The researcher is aiming to identify taken for granted actions and practices in people’s social worlds, identify tensions and contradictions, and find “clues” to connect their experiences with the ruling relations (Bisaillon & Rankin, 2013). Engaging informants in conversation, enables both researcher and the informant to actively participate to identify texts and discourses that are being enacted.

Analysis of the data is ongoing throughout the whole research process. The goal of the interviewer is to “elicit talk that will not only illuminate a particular circumstance but also point toward next steps in an ongoing, cumulative inquiry” (DeVault & McCoy, 2012, p. 383). In addition to audio-recording the interviews, I made notes both during the interview and following the interview. During the interview, I used the notes to identify where I needed more information about what happened and how it happened. I also began to identify texts and discourses that were being enacted, or where these were obscured. I noted points of tension, frustration, or concern. I used these notes to frame further questions in the interview. Following the interview, I immediately made notes on my key learnings, including the new knowledge I’d gained, the ongoing gaps in my knowledge, and the disjunctures that were beginning to emerge.

Interviews are not required to be standardised. Each interview provides more information, enabling the researcher to consider what further questions and information are required to continue to build up the picture of the coordinative processes (DeVault & McCoy, 2012). In dialogue with the primary informant, I found that each interview covered very different ground. Institutional ethnographers are not looking for themes. Instead, they are looking to

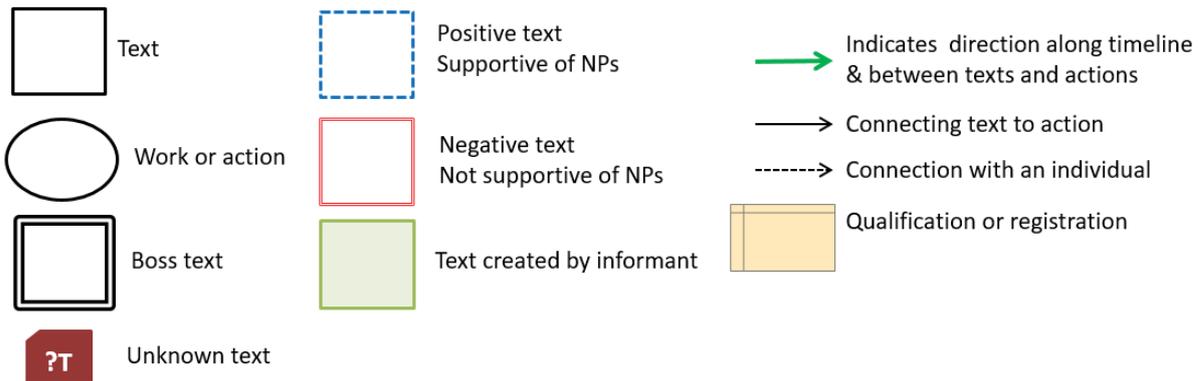
build up the extended organisational processes piece by piece (Smith, 2005). I found each interview provided different information.

Presenting maps as snapshots of overall process provides the reader with an understanding of the enormity of the entire journey, and the various obstacles, challenges and conflicts faced. While some of the institutional processes and texts that the primary informants encountered as barriers have now changed, the primary informants' experiences remain relevant. Such experiences in the present are embedded in a historical trajectory, which at the same time shapes the future (Smith, 1999). The NPs experienced difficulties and complexities as they engaged with the texts in order to progress along the NP pathway. In turn they themselves become active in the construction (or reconstruction) of discourse and texts.

Full mapping of the primary informant interviews was undertaken following completion of the phase one interviews of the primary informants – the NPs and NP candidate. I drew particularly on the work of Smith (2006a), Turner (2006), and Clune (2011). I used an artist sketch book to draw and refine maps, enabling me to identify connections, disjuncture, and places of particular interest. As the mapping process unfolded, it became apparent that different approaches and intensity of detail to the mapping were required for various aspects of the data. I noticed that the text-work-text sequence could be applied using different levels of detail, from the minutiae of some sequences of activity regarding a particular incident, to a broader timeline of activity and texts which perhaps took place between two and fifteen years.

For each primary informant a map was created using the following symbols (see following page, 126).

## Mapping Symbols

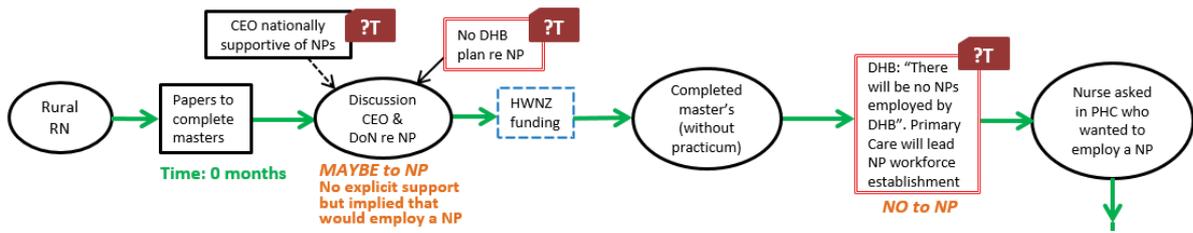


Broadly, I used three approaches to the mapping, and identified parts of the map against the scaffold map developed and shown earlier in the chapter.

### 1. Broad timelines relating to the scaffold map

Mapping was used to show what happened on the journey to become a NP candidate; to gain employment as a NP; or to implement NP services (or not). Texts that were knowingly referred to by the informants were identified on the map. This included the 'story' of how the nurses progressed on their career pathway, identifying both hurdles and facilitators, and how as an authorised NP they developed NP services within their practices and communities. The timelines might stretch from just a few months to many years, with the informants recalling what they now perceived as relevant and pertinent to the researcher's questioning.

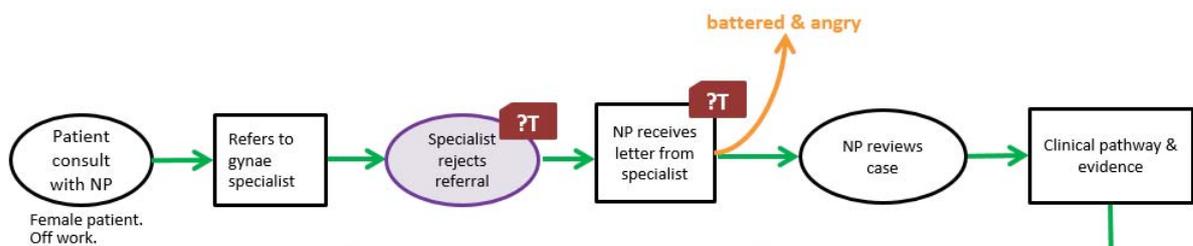
The first approach to mapping is given in the example shown below. The section shown is just one small segment of the map created for this particular informant, which is shown in full in chapter five (page 164). This segment, below, shows a part of the text-work-text sequence of activity that the RN (Liz) undertook to find a position as a NP over a long period of time (see Map 3 on opposite page 127).



**Map 3: Liz:** Excerpt of map showing text-work-text sequence

## 2. Specific examples of text-work-text sequences

Mapping using text-work-text sequences was used to demonstrate specific examples or incidents, which generally identified and described a barrier. The map revealed the specific work activities that an informant had to undertake to overcome (or not) a certain barrier. This approach is described in detail by Turner (2006), and is more linear. For example, in this sequence, the NP (Alana) is describing the process she went through to ensure a patient received the appropriate medical intervention. Again, this is a segment of the map shown below, and is in full in chapter seven (page 221). The actual sequence of what happened, shows the response at the time the NP read the letter (the text) received from the medical specialist. At this point she described her embodied experience as “battered and angry”.

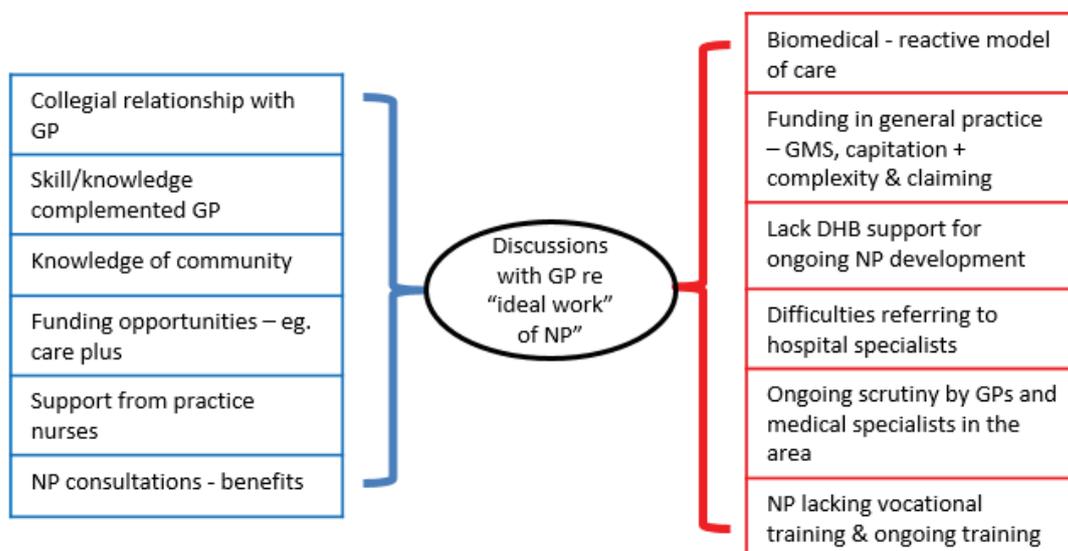


**Map 4: Alana:** Excerpt of map showing text-work-text sequence

## 3. Complexity of texts

Through the mapping exercise, I became increasingly aware that there were often multiple texts that had been or were being enacted within the local environment by the NP. I was interested in capturing these texts, both to show the discursively mediated texts that were positively shaping the work of the NP or NP candidate, and those that had been identified

as negative or problematic. Together, these texts created a complex institutional environment that concerted to control the progress of the RNs and NPs as they sought to deliver NP services. The map, presented below, shows the discursively mediated texts that entered into the local setting as the NP (Elaine) discussed with the general practitioner how to develop NP services in the practice. The competing discourses and texts were identified through the interview. This map was used for further textual analysis.



**Map 5: Elaine:** Competing texts and discourses in local setting sequence

On all the maps I noted tensions, contradictions, and concerns experienced by the informant as they enacted texts in their local situation. Such embodied experiences often indicate a disjuncture between their reality and the institutional reality. Some described the impact on their health, or how they felt “frustrated”, “angry”, or “confused” by their experiences. The stories that describe their journeys were humbling. However, while my empathy and admiration continued to grow, I (as a novice institutional ethnographer) understood that it was through these disjunctures that further exploration would reveal how their experiences were being institutionally coordinated. The disjunctures were places that neither I, nor the informant, could reconcile nor fully comprehend during our dialogue at interview.

## Textual analysis and secondary informants

The detailed mapping of each primary informant interviewed provided information on the various texts that were coordinating the actions of the NPs and NP candidates, and provided guidance on where to go next. As with most ethnographic inquiries there has been an abundance of data generated, and multiple opportunities to pursue various institutional practices. Indeed, I have spent many days pursuing a particular series of texts, only to decide that I was losing sight of the purpose of the study, or the standpoint of the primary informants.

Clune (2011) developed an acronym, INSPECT, based upon a range of authors' works, that I found particularly helpful:

**I:** What is **I**nteresting about this map?

**N:** Are there **N**ew findings that require a revision in the methods, interview questions or procedures?

**S:** What **S**equences of action or work are evident?

**P:** Who are the **P**eople identified in this map?

**E:** Are there other **E**vents that are influencing the sequence that may be (in)visible to others?

**C:** Are there **C**ommon **C**onnections or **C**ircumstances with this map and experiences of other informants?

**T:** What **T**exts are talked about?

(Clune, 2011, p. 62)

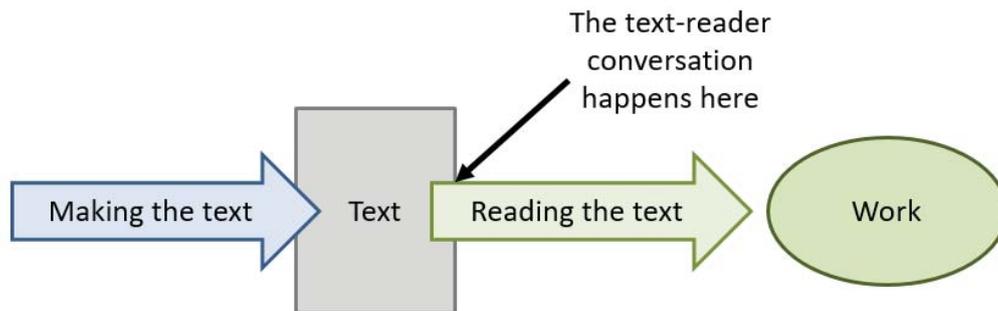
Choosing the disjunctures to pursue was a challenging process. An IE researcher is often immersed in the field for a considerable time before identifying the entry point(s) to the IE, particularly if the experience is complex (Bisaillon, 2012; DeVault & McCoy, 2012).

However, I returned frequently to the purpose of an IE being to create a map of a particular area of the social world, by placing a magnifying glass over that area to show the coordinating effects of the institutional processes (Smith, 2005). I have restricted my focus for further analysis to exploring tensions expressed by the primary informants that remain contemporary. Textual analysis, and identifying and interviewing secondary informants, was based upon exploring particular tensions and disjunctures arising from the primary informant interviews.

The first part of textual analysis is to identify texts that have been enacted by the primary informant. I use an example here of an experienced nurse in primary health care who needed to demonstrate achievement of specific NP competencies for her portfolio. I have used italics and bold to highlight what was said, and below identify the particular texts to which she referred:

[A]nd it feels like you've done this huge drop, and you're starting at Kindy [child care] all over again. I don't know how to explain it really.... at least you felt like that – you just know that there's so much more that you have to do, but you start worrying about, like, the *leadership side of things and policies and procedures and... the business side<sup>(1)</sup>* of things a little more than what I would have any other time. *This year I joined the Leadership Nursing Group<sup>(1)</sup>* .... I wish they had been around three years ago – that would have been awesome, because they're all really either senior nurses or management, and it's [the group's] just got all the answers [such as] where all the funding comes from.... It's a new group that just started this year, but they've been really good. [Name] - she's our Director of Nursing at the hospital. *So it was just for the whole community – we've got primary health care nurses, mental health nurses, all community nurses to start joining together and linking in with each other, you know, on a leadership level to do well for the patients really in [our district]<sup>(2)</sup>.*

The first highlighted quote (1) directly connects the primary informant with the authoritative text. She knows the Nursing Council competencies<sup>34</sup> for the NP scope of practice, and has engaged with the text. In essence, she had a dialogue with the text, and her resultant action, or work process, was to join the Leadership Nursing Group. Smith (Smith, 2006a) refers to this as the text-reader conversation, shown in the following diagram:



**Map 6: Diagram showing the text-reader conversation.**  
Adapted from Smith (2012)

The primary informant knew about the Nursing Council text, a reproducible text. Further the primary informant links leadership with working with other nurses for the benefit of the community (highlighted 2). Here she is connecting with the extra-local layers of institutional discourse and texts, perhaps, for example, nurses' work to reduce health inequalities, and the importance of working collaboratively. She identifies that the Director of Nursing (DoN), who set the group up, is herself hooked into the institutional ruling of the DHB. Through this group, the primary informant gained access to other authoritative texts, such as funding streams that would give her the knowledge to develop a business case for her employment. This one example of an interview shows how the researcher could further the inquiry by exploring texts governing nurse's work and leadership, as well as

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<sup>34</sup> The competencies changed in 2017. NPs are expected to demonstrate advanced interpersonal, leadership, and management skills (Nursing Council of New Zealand, 2017c), however, the requirement to demonstrate leadership competencies outside of the clinical area is no longer required.

undertaking an interview with the DoN (a secondary informant) to explore the text-based work process of the establishment of the leadership group.

## **Trustworthiness and rigour**

An institutional ethnographer is expected to have existing knowledge of the social world from which the inquiry begins. There are two particular risks. The first is that the researcher's experiences and entry points for further inquiry is prioritised over the informants' experiences; and second, that as the researcher is also likely to have authoritative knowledge they may conceptualise the experiences of the primary informants, limiting the opportunity to explore how the social world of informants is organised in reality. I was aware as I started this research of my own experiences, and levels of frustration in my earlier struggle to become a NP. There were several strategies I used to ensure that the research remained trustworthy.

Firstly, I revisited the original transcripts of the primary informants to ensure I had accurately used their information. I looked for consistencies through their transcripts, as well as comparing with the notes I took through and following the interview. Secondly, I took various opportunities to informally discuss mapping and my process of exploring the extra-local levels with colleagues and NPs, as well as returning to the group of NPs to show and discuss findings with them. I continually searched for and revisited the literature. This included the academic literature, grey literature, as well as popular medical and nursing press. When tracing texts, I endeavoured to identify direct connections between texts, including phrases used and references. Both these strategies supported the rigour of the research. Thirdly, I endeavoured to practice reflexivity through the research process. Early in the research process I used journalling to explore my experiences and created maps to identify my knowledge, connections, and disjunctures. From my standpoint I could only know a small piece of the puzzle. I wanted to know about others' experiences in order to

build the knowledge of the organisational ruling that was operating. Mauthner and Doucet (2003) describe how there is a limit to how reflexive we can be through the research process. They identified how their data analysis was “infused with epistemological and ontological assumptions” (p. 415) that they only became aware of after the research ended.

Throughout the research I have declared my position, and I have endeavoured to explore the data and texts with a curiosity not steeped in theoretical or authoritative knowledge. However, I am well aware that there are limitations to my reflexivity, which may only be revealed at a later stage, as Mauthner and Doucet found (2003). Throughout the writing phase I have had moments where I have been jolted by the recognition that I am slipping into theoretical knowledge. For example, I found myself making assumptions of the informants’ paradigms of practice based upon the social justice and health inequalities literature. I needed to return again to the original transcripts to identify actualities of the informants. I am certain that as I begin to discuss the findings of the research with a wider audience I will discover further epistemological assumptions.

## **Presentation of findings**

The findings are presented in three chapters. Chapter five explores the journey from RN through to authorisation as a NP. The scaffold map is used to frame this chapter and show the text-based work undertaken by nurses to become NPs as well as the texts and discourses that entered into their local situation that limited their progress. I show a map of Liz’s journey depicting the key texts and work processes on her three-year journey to ultimately *not* becoming a NP. Chapter six explores the contested space of general practice. Beginning from the actualities of the NPs and NP candidates, institutional texts and historical discourses that are continuing to limit the development of the NP role in general practice are explored. Texts are traced through from the standpoint of the primary informants to global texts produced by medical associations. Finally, in chapter seven, the disjuncture is

explored between the fragmented system of health and health policy, and the reality of the experiences of the NPs as they try and provide services in the best interests of their communities. In this chapter I draw on an example of a general practice that chose to enact the texts to promote the establishment of NPs in the interests of their local population.

The context in which nurses are becoming NPs is in a continuous state of flux. The ruling relations are dynamic, and texts and discourses regularly change, sometimes with considerable alacrity. In the findings chapters, I have endeavoured to include texts that are contemporary and remain particularly pertinent to rural nurses, while focusing less on texts that have perhaps solved identifiable barriers. Over the last five years significant changes have been made to: the scope of practice, education and assessment of NPs (Nursing Council of New Zealand, 2014b, 2015a); the access to funding through HWNZ with identified career pathways (Ministry of Health, 2015a); the establishment of a Nurse Practitioner Trainee Programme, funded by HWNZ and delivered by The University of Auckland and Massey University nursing schools (Nursing Review, 2015); to medicines legislation (Medicines Amendment Act, 2013); and to various pieces of legislation enabling NPs to practice within their scope of practice (Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, 2015).

## **Summary**

In summary, this chapter has provided an account of the methodological framework used for the study, the ethical review process, data collection, and analysis strategies utilized. At the outset of the study, and based upon authoritative texts, I developed a scaffold map showing the expected journey a RN would take to become a NP, and then work in practice. I took the methodological approach to begin from the standpoint of the primary informants, and from there explore the texts entering into and being enacted in the local situation. The first phase of the study was to interview the primary informants, the NPs and NP candidates.

Using a mapping process to identify the text-based work process (Smith, 2006a; S. M. Turner, 2006), each interview was mapped using various strategies. These visual maps were particularly useful in helping to identify points of connection and disjuncture, as well as showing the extent of the work processes undertaken by the NPs and NP candidates. In addition to identifying points of disjuncture, tension, or conflict, I also highlighted those texts that the NPs and NP candidates found particularly useful in helping them to proceed along their journey to become NPs. Points of disjuncture signalled the entry point to exploring the extra-local textual relations, explored by tracing texts and interviews with secondary informants. The findings chapters follow.

## Chapter Five

### Working to Get There: Clinical Practice and Education

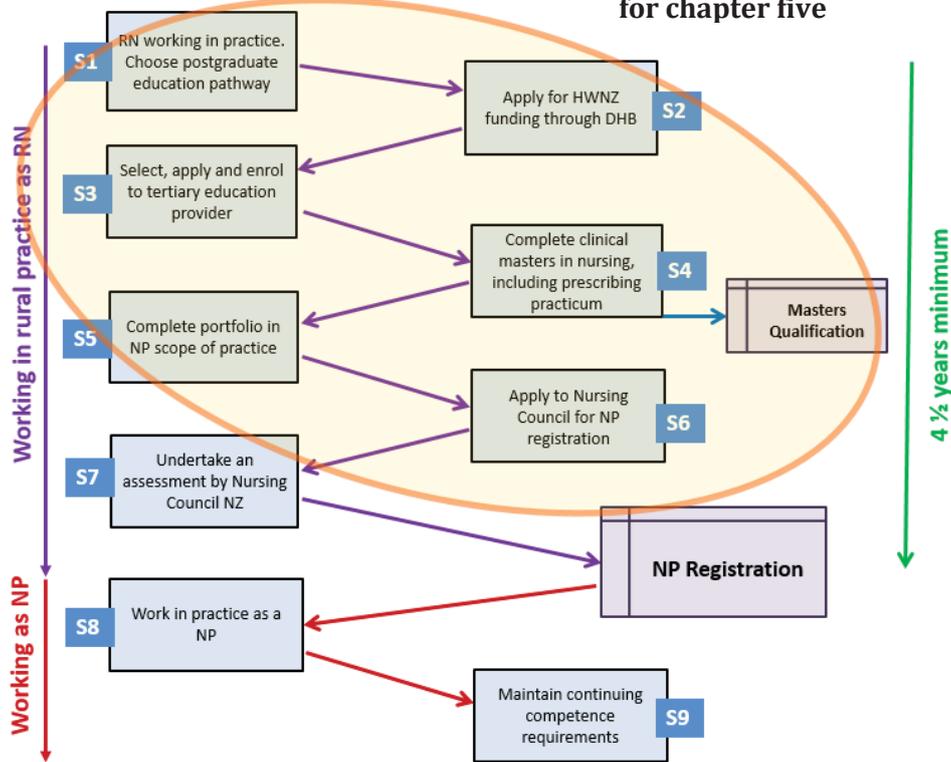
#### Introduction

The regulatory, educational, and legislative framework for developing the New Zealand NP workforce was based upon international evidence, processes, and consultation both in New Zealand and overseas. The outline of the required framework was described by the Ministerial Taskforce on Nursing (1998). The Nursing Council of New Zealand produced the processes and documents to govern the authorisation process, including the educational and practice pathway. The New Zealand Primary Health Care Strategy (A. King, 2001) signalled the importance of developing the nursing workforce to meet the health needs of populations. These purportedly powerful texts sowed the seeds of expectation for the nursing workforce. Nurses intending to become a NP engaged with these New Zealand texts through the Nursing Council, professional journals, nursing organisations, tertiary institutions, conferences, and word of mouth.

In chapter four I described the methods used to explicate the ruling relations from the standpoint of the NPs and NP candidates. Interviews with the primary informants were mapped to begin to identify the texts that were institutionally coordinating their actions and experiences. At the beginning of an IE, the specific direction and focus of the inquiry is often unknown. Smith (2005) calls this the “territory to be discovered” (p. 41). In this chapter, I use data from the primary informants to describe their experiences and actions as they gained the necessary clinical and educational experience and knowledge, and identify the texts entering their local setting. Using the analogy that Smith made to a hiking trail in a regional park, an institutional ethnographic inquiry is likened to placing a magnifying glass

over a particular area of the map (Smith & Turner, 2012). The area shown on the scaffold map below is the focus for this current chapter.

**Map 7: Scaffold map showing area of focus for chapter five**



Using the scaffold map as a framework, I have described and mapped the actualities of primary informants' experiences and actions. Through this chapter, while I have identified some disjunctures and tensions, I have also identified texts and discourses that facilitated and supported the nurses' pathway to become a NP. As well as the difficulties, I also wanted to understand the ad hoc success of NPs who had developed a position as a NP in rural primary health care.

I begin this chapter by presenting a map summarising the data provided by the NPs and NP candidates in relation to the development of their advanced clinical practice, and their educational and registration pathway. In the sections following this, I describe and explore

firstly, the data from the primary informant interviews relating to their work as advanced nurses in rural primary health care; and secondly, the educational and registration pathway. I focus on the work that nurses undertook to secure funding through the required textual process and the textual work of nurse leaders to promote NPs, both of which remain contemporary issues. Finally, I show a map of Liz's journey as she repeatedly worked to get herself into a position where she could become a NP. Data from this chapter then leads to chapters six and seven where I further explore the tensions and disjunctures, tracing the texts and discourses into institutional layers to identify the ruling relations organising the establishment of the NP workforce.

## **Work and texts facilitating the nurse practitioner pathway**

The Nursing Council requirement is that intending NPs have worked within their area of practice (such as primary health care or *whānau ora*<sup>35</sup>) for at least four years. In this study most primary informants had been working in their area of practice for fifteen years or more. The years spent on their postgraduate education pathway ranged from four years to twelve years. At the outset of their tertiary education studies, for many, NP registration was not yet available in New Zealand. At the time of interview, those not already NPs, were working at the equivalent level of an expert RN nurse (competence level 4)<sup>36</sup> (National Professional Development & Recognition Programmes Working Party, 2004), and had either completed or were completing their clinical Master's in Nursing.

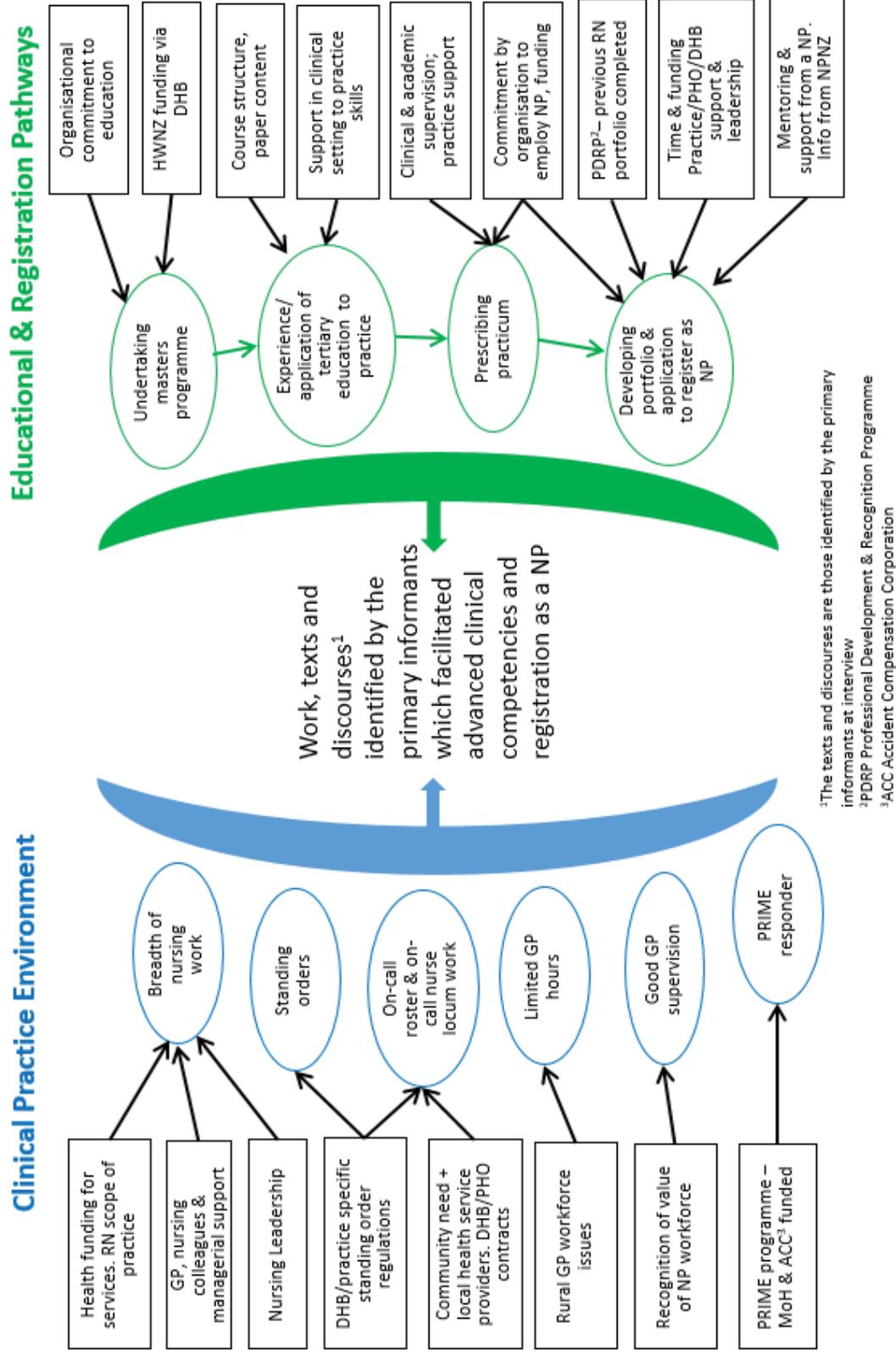
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<sup>35</sup> NPs registered with the area of practice "*whānau ora*" work with Māori communities and *whānau* (families) to provide primary health care underpinned by Māori cultural values.

<sup>36</sup> Professional development and recognition programmes (PDRPs) are approved and audited by Nursing Council and can be run from DHBs, PHOs, NGOs and private health providers. Participating nurses will not be required to undertake a recertification audit (Nursing Council of New Zealand, n.d.-a). PDRPs may offer levels 2,3,4 (competent, proficient, expert), based upon Benner's (1984) framework from novice to expert; and senior nurse. At the completion of an undergraduate nursing programme, students have achieved level 1 (novice).

Data from the interviews was explored in relation to the clinical practice environment, including the development of advanced practice nursing competencies, and the educational and registration pathways. While an IE is often concerned with identifying the disjunctures and tensions, the primary informants expressed their interest for the study to identify those texts and discourses that facilitated their development. As I undertook the interviews, I was struck by how the NPs engaged with and enacted texts that supported their practice and educational development, although often their work began from a point of tension. The journeys and experiences of the primary informants all varied. The NPs and NP candidates took opportunities where they could practice as advanced practice nurses, and acted upon these to further their career pathway. For example, the shortage of rural general practitioners undertaking out of hours' primary care, resulted in RNs working with DHBs and general practices to change the policies governing out of hours' work, enabling RNs to provide this cover.

The map shown overleaf (page 140) provides a summary of the data from the primary informant interviews. The circles represent work and activities undertaken by the nurses, and the boxes represent the texts (where identified in the interviews) coordinating their actions. The map does not show individual informant's text-work-text sequence. The purpose of this map was to show the discursively mediated texts that the primary informants engaged with and enacted that facilitated their progress to become NPs.



Map 8: Work, texts and discourses facilitating development of advanced clinical nursing competencies

## Advanced rural nursing practice

### Diversity of the work and stretching boundaries

Several participants described their work in isolated communities where they were required to deliver a full range of primary health care services such as immunisations, well child checks, cervical smears, long term conditions management, repeat prescriptions, acute and minor illness and injury. Shona, for example, described her work as a rural nurse specialist, prior to registering as a NP:

You were everything [as a rural nurse specialist]. If you were worried about an elderly person, you put on your district nurse hat and you went out to see them.... If you were worried about the children, you could wander down to the school and be the public health nurse. You had this wonderful flexibility. You saw the women antenatally... and for the first six weeks<sup>37</sup> [postnatally]. And of course the scary part of it was that you were the emergency service provider. There was a local ambulance, basic trained ambulance crew, and so you went to all the accidents. (Shona)

With the advanced rural role comes responsibility and autonomous practice (Cant, Birks, Porter, Jacob, & Cooper, 2011; Howie, 2008a). Being the key health provider in an area, with just weekly visits from a general practitioner provided the nurses with the experience of working independently at an advanced level, and similarly prompted their desire to learn more and become a NP:

I was being asked to do what was outside the scope of practice for a RN, and I know everybody doesn't agree with me over that – especially people like the DoN (Director of Nursing) at the time. But for me, I felt that I didn't have enough knowledge, and I didn't have the authorisation of my professional body to be making the decisions that were expected of me in that role, in

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<sup>37</sup> Lead maternity carers, either a midwife, or less usually, a general practitioner, are contracted to provide postnatal care for the first six weeks following birth. In rural areas, nurses have historically often undertaken this role, and in some areas continue to do so.

that remote community. And so that is what pushed me on [to be a NP].

(Shona)

The isolated environment resulted in Shona at times undertaking health care work, particularly in emergency situations, without access to medical support. Shona described how the general practitioner was usually a locum, often with limited rural experience, and often not available (this is described further in chapter seven). At times she used her nursing colleagues to discuss and support her clinical decisions. Shona is describing a tension experienced between the regulatory texts governing her practice as a RN, and the health needs of patients in a highly isolated area. The scope of practice of a RN is stipulated by the Nursing Council (Nursing Council of New Zealand, n.d.-b). While the RN scope of practice is broad, enabling nurses to work at an advanced level of practice, it includes the following statement:

Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards.

(Nursing Council of New Zealand, n.d.-b)

The statement by the Nursing Council is a powerful organising discourse for nurses in New Zealand. Professional nursing journals, such as Kai Tiaki, and the national media, report on adverse events involving nurses investigated by the Health and Disability Commissioner (HDC)<sup>38</sup>. Decisions and case notes are publicly available on the HDC website, and nurses may be referred on to the Nursing Council for disciplinary action. Any member of the public may also raise inquiries or complaints about a nurse directly to the Nursing Council. Nurses have to complete an annual practising certificate to the Nursing Council declaring they have

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<sup>38</sup> The Health and Disability Commission ([www.hdc.org.nz](http://www.hdc.org.nz)) was formed following the enactment of the Health and Disability Commissioner Act 1994. The Act was passed to implement the recommendations following the 1988 Cartwright Report on the unethical practices of both women left untreated following cervical smears identifying abnormal cells, and female babies subjected to cervical smears. In 1996 the Code of Health and Disability Services Consumers' Rights was introduced, and a summary has to be displayed in all health settings. This includes the consumer's "right to complain" (Right 10).

maintained the required standard for continuing competence, as required by the Health Practitioners Competence Assurance Act 2003. This annual activity ensures the nurses' engagement with the Nursing Council as a powerful ruling force in their nursing world.

Shona also stated that the DoN would not agree that she was working beyond her scope of practice. Had the DoN acknowledged Shona's 'out of scope' work she would have been required to take organisational action, by either providing access to either a general practitioner or NP. The work that Shona was undertaking to deliver rural primary health care services goes unrecognised by the organisation. A disjuncture is present between the institutional reality as conceptualised by the DoN, and the lived experience of Shona in her local setting as she delivers health care services. The Nursing Council regulatory texts are enacted by Shona resulting in her discussing her decisions with her nursing colleagues when she is unable to reach the locum general practitioner. Further, Shona experiences a tension between her existing knowledge and competence, and the knowledge that she believes is required to deliver rural health services. Shona engages with the regulatory texts that govern RN practice, the NP framework, and her knowledge of the health needs of the population, resulting in a work process to become a NP.

Leanne further described her own and a colleague's authorisation as a NP, describing the tension experienced:

And it's certainly helped us a huge amount. We sort of felt at the time that probably we needed to be working [as a NP]. We needed to have done prescribing and I think [she] and myself were just in the process of doing that, because we found that without the GP we were actually working illegally. (Leanne)

Both Shona and Leanne identified the tension created between what they were doing as nurses in order to provide the required health care to the community and that to do this

required them to work at times “illegally”, beyond their scope of practice, or “stretching the boundaries” (Leanne). This tension was a key driver for both to pursue registration as a NP.

### **Standing orders**

Nurses in New Zealand are not able to independently prescribe medications, unless they are a designated prescriber (Medicines (Designated Prescriber: Registered Nurses) Regulations, 2016) or an authorised prescriber (Medicines Amendment Act, 2013), as, for example, is a NP. However, other nurses may administer and supply medicines through standing orders (Medicines (Standing Order) Amendment Regulations, 2016)<sup>39</sup>. Standing orders are widely used in healthcare, including primary health care, with the purpose of improving “access to medicines through the most efficient deployment of the available workforce” (Ministry of Health, 2016a). The introduction of standing orders in rural practices was driven particularly by the reduced access to general practitioners (Scott-Jones, Young, Keir, & Lawrenson, 2009). However, the process by which standing orders have been applied in practice has been variably used in primary health care, with often inadequate understanding of the legal requirements (R. Taylor, McKinlay, & Morris, 2017; Wilkinson, 2015).

A standing order is a written instruction issued by an authorised prescriber. In primary health care such instructions are generally used for common health conditions, such as fevers, gout, respiratory conditions, sexually transmitted infections, sore throats, urinary tract infections, and contraception, where assessment, diagnosis, and treatment can safely follow best practice guidelines. The purpose of the instructions is to enable the nurse to manage that particular episode of the patient’s care, without the patient consulting with a general practitioner or NP. The opportunity to work under standing orders was identified

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<sup>39</sup> The Medicines (Standing Order) Regulations 2002 were updated in 2016 to enable nurse practitioners (and prescribing optometrists) to issue standing orders so that other health professionals can administer and supply prescription medicine under those standing orders.

by informants as facilitating knowledge of medications and prescribing practice. Ellie stated:

The advantages as a RN in a rural locality was that you worked under extensive standing orders ... at an advanced role. Clinical decision-making was based on clinical findings. If we were outside of the clinical parameters for our standing orders, then we had to sell [our findings and decisions] to the consultants [in the ED]. It made us actually work ... at a good level, at a safe level, and understand prescribing using standing orders. So that was one thing that gave me the confidence to think that "Yeah, I can actually do this, I can actually do it well". (Ellie)

Ellie is describing the work processes around standing orders, both to develop her knowledge and understanding of prescribing practice, and to be accountable for her practice through clinical decision-making. Should the standing orders not cover a particular condition, then Ellie had to discuss and “sell” her clinical decisions in a phone call to the consultants of the emergency department (ED). The necessity to practice at a “safe” level, textually drove her work to develop her advanced knowledge.

Leanne identified both standing orders and care pathways as increasing her ability to practice at an advanced level, encouraging her assessment and diagnostic skills. The lack of, or reduced, access to general practitioners provided a space where rural RNs could step in to fulfil a prescribing service to local communities. The qualitative New Zealand study by Taylor et al. (2017) confirmed that the use of standing orders supported the extension of the nurses’ role, enabling RNs to work at a more advanced level of practice, offering a wider range of services to patients in their communities, and in turn promoted teamwork in practice. The issuer of a standing order has overall responsibility for the standing order, and is required to ensure the competency of those administering/or supplying the medicines. The Ministry of Health (Ministry of Health, 2016d) guidelines state:

To meet regulatory requirements, a person working under standing orders must have the competency and training to be able to make an assessment that the standing order applies to the presenting patient, the competency to administer and/or supply the medicine, and the knowledge to assess the contraindications and/or exclusions. (p. 4)

Standing order legislation and the regulation of RNs to be accountable for their practice results in a substantial text-based work process at the local level. RNs are required to utilise clinical decision-making to assess and diagnose, and have knowledge of both the condition, and the medication itself, including any contra-indications or red flags to the standing order (Wilkinson, 2015). Most of this work to develop their competency is undertaken individually by the RNs. Appropriate use of the standing order framework does provide an opportunity for RNs to extend their practice and to engage with the issuer of the standing order regarding ongoing education and the development of skills.

### **On-call rosters and PRIME (Primary Response in Medical Emergencies)**

Rural nursing has consistently been described as an area of practice requiring advanced knowledge and skills (K. L. Francis & Mills, 2011; Hegney et al., 2014). Rural nurses are specialist generalists, working diversely across the life span, and include health promotion, illness prevention and screening, the management of people with existing health conditions, and people newly presenting with illness or injury (Cant et al., 2011), as reiterated by Shona (see above). Further, nurses in rural settings are more likely to be a part of on-call rosters, and being part of the community, are often informally on call but not rostered (Dahrouge et al., 2014; R. Thompson, 2008).

Ellie described how her on-call work in rural settings particularly promoted her clinical decision-making skills. She had moved from an urban practice to a rural clinic to continue on her pathway to become a NP:

In the rural setting I was having to think "Hold on, make a clinical decision. What is your clinical decision based on?" And also, in rural [practice] you've

got no instant diagnostics ... you can't rely on radiology, you've got to rely on your clinical findings. So you need good history-taking, good clinical findings, good differential diagnosis, and it's making a plan from there. So, I think that whole process actually made me consolidate my practice. (Ellie)

Ellie is describing how her work in the rural setting was different from her work in an urban practice where the general practitioners took the lead in primary care provision. She is highlighting that the ruling relations in rural areas and rural health are different to those coordinating the work of RNs in rural practices. The remoteness and reduced access to health services, including doctors and diagnostics, organises RNs in rural areas to work at an advanced level.

Leanne provided out of hours' cover at weekends in rural areas with support by phone from the emergency department or a general practitioner. She carried with her a range of medicines as she undertook house calls. While Leanne identified that providing an out of hours' service was an opportunity, the extent of the work she undertook to practice at an advanced level was extensive:

You had to do your assessment on your patient, you rang the doctor and they would do the diagnosis - even though you might have known what was going on - they did the diagnosis and they prescribed. We gave the medications that they advised. And I really enjoyed it. (Leanne)

Lying behind this statement is a considerable body of knowledge organising Leanne's assessment so that she can adequately provide all the necessary information for the doctor to reach the diagnosis. For this system to work, the doctor needs to trust the ability of the nurse to have adequately undertaken an assessment, providing all the necessary data to make a diagnosis and prescribe. In Leanne's statement she describes how she had already reached the diagnosis. However, the institutional processes require that she discusses each case with the doctor. The regulatory and historical texts establishing the boundaries between medicine and nursing are coordinating the nurse's work. While Leanne knows this

to be the case, she is alluding to the notion that she is capable of doing this work, and this gave her the confidence to pursue her NP registration.

Lisa, as a NP candidate, described the support that she received from the only general practitioner in the practice, both through her prescribing practicum, and the year following that. At the same time, because there was only one general practitioner who worked four days a week, Lisa was the senior nurse on the fifth day, and when the general practitioner was on leave:

If you've got good relationships and trusting relationships with other health professionals, you'll be all right. I still work casually in the ED as well, so I've got good relationships there – so that's another really good safety net – like I can ring the doctors any time, and I'm definitely not scared of asking for help with any patients. It was a good trial run, actually when [the GP] went away for a week and there were just no locums. So we just had a nurse-led clinic for the whole week, so that was good. I didn't realise how scared I was, because I suppose you're never comfortable when you're in nursing practice [on your own], but ... it was good. It was huge, a big growth. It was just "Oh shit, this might be what it's going to be like all the time", but it was cool.

(Lisa)

Again, Lisa described how a supportive environment with a general practitioner resulted in her being required to take the lead in the practice. She further shows how she works to maintain relationships with the emergency department to support her in her nursing work. While "scary", she recognised this opportunity to support her advanced practice and future registration as a NP.

In addition to on-call work within the practice, rural RNs are often trained as a PRIME (Primary Response in Medical Emergencies) practitioner. The PRIME scheme was developed in New Zealand in 1995 to provide a consistent and coordinated response to medical emergencies and trauma in rural communities (Horner, 2008). The health reforms

of 1993 that had introduced competitive contracting resulted in centralised emergency communication centres that excluded general practitioners and advanced rural nurses who had previously responded to rural emergencies. Further there was a recognition of the inconsistency of training, knowledge, and skills in the emergency situation (Hore, Coster, & Bills, 2003). A PRIME service provider is required to complete a PRIME training course approved by the Accident Compensation Corporation<sup>40</sup> (ACC) and a two-day refresher course every two years. The objectives of PRIME are to provide “primary assessment, essential resuscitation, and the rapid and safe delivery of patients to the appropriate place of definitive care” (Hore et al., 2003, p. 2). While ambulance crews are also sent to attend, the PRIME responder is often the first on the scene.

Shona, Leanne, and Ellie all provided examples of emergencies that they attended as rural nurses and PRIME responders. Emergency events included heart attack, ruptured spleen, motorcycle accident, suicide, helicopter crash, sudden infant death, sporting head injury, car accident, shooting (hunting) accident, hit and run, farming accident, and building accident. The nurses described how they undertook intubation and cannulation, provided emergency pain relief, and undertook resuscitation in remote and difficult areas to access, such as fields, on the side of the road, and in the dark, though often with the help of ambulance crews. While this opportunity to advance their emergency skills was considered invaluable, Shona cautioned that the PRIME training did not prepare a nurse for some of the emergencies faced. She also identified that RNs often undertook their PRIME training early on in their experience as rural nurses, and were not always adequately supported. She stated:

There wasn't enough support for, you know, some of the awful situations that arose over there. And sometimes not enough support for afterwards...

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<sup>40</sup> The Accident Compensation Corporation (ACC) is a Crown entity responsible to the Minister for ACC responsible for administering New Zealand's universal no-fault scheme for work and non-work injuries. The scheme provides contributions to treatment costs, loss of earnings, return to work schemes, and home and vehicle modifications.

The powers that be didn't know that. There wasn't, and still isn't, sufficient acknowledgement of what they are asking nurses in those roles to do. I'm sure the DoN would argue with me. (Shona)

As before, Shona is identifying a disjuncture between her actual experiences, and the institutional view of rural nursing work. The seriousness of situations encountered and the ensuing stress were minimised by the DoN. She described how this drove her forward to pursue registration as a NP:

My push to have more knowledge, to become a NP – to know that the decisions I was making as an autonomous practitioner were OK and that I was OK to do that. (Shona)

Sue then asked:

And did being authorised and having that additional knowledge, did that give you more confidence to do your work?

Shona replied:

Yes, it did. It did. I felt that I had been authorised by the professional body to say that I actually could do this work. I wasn't just stretching the boundaries.

The primary informants have all described how the ruling relations of rural health, including the shortage of general practitioners, reduced diagnostics and other health services, the need for on-call work, their professional duty to deliver health care, and their regulatory obligations to be competent and work within a RN scope of practice, all concerted their efforts to pursue registration as a NP. The need to deliver advanced practice nursing services rurally to meet the health needs of the population provided further incentives to enact texts to become a NP. While tensions existed, the primary informants took these as opportunities and engaged in substantial work processes to deliver services.

## The educational pathway

Only one of the primary informants in this study had the intention of becoming a NP at the outset of their postgraduate educational studies. Lisa undertook her RN training as a mature person, and had commenced postgraduate study two years after registration with the explicit intention of becoming a NP. At the time of the interview she was in the process of completing her prescribing practicum. Most nurses commence their postgraduate study intending to complete perhaps a postgraduate certificate, possibly a diploma, and occasionally a master's. Hannah, for example, described a long journey that began with Ministry of Health funding to train Disease State Management nurses in the early 2000s.<sup>41</sup> Her nursing lecturer from the postgraduate certificate programme encouraged her to then undertake her diploma, and finally Master's in Nursing. Leanne described the postgraduate diploma in primary rural health care:

It was an excellent course because it was designed by practitioners for practitioners, and it was what we needed to know. The other thing, of course, was [the lecturer] with her enthusiasm, bounced up and said to us all: "You realise you're half way towards your master's?" And ... there was a group of us – we pushed ahead, we got our master's and then I went for my NP registration. (Shona)

In this regard following a career pathway to become a NP is an entirely different journey to the one that general practitioners pursue. Doctors wanting to become a general practitioner apply for the General Practice Education Programme (GPEP) which is a 36-month training programme (Royal New Zealand College of General Practitioners, n.d.). The training is funded through Health Workforce New Zealand (HWNZ). Doctors are required to be employed by the training facility (hospitals and general practices), and they themselves are

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<sup>41</sup> Disease State Management postgraduate certificate programme was aimed at improving nurses' knowledge and skills for managing people in primary health care who had specific long term disease conditions (in the main respiratory, cardiovascular or diabetes) with the goal of reducing health inequalities for Māori.

expected to pay for professional fees and the final exam at the end of year three. A master's in clinical nursing programme is different in structure. Nurses are required to complete 240 credits for their master's, usually part-time (while working in practice) by undertaking courses worth 30 credits per university semester. Certain courses are core to all programmes as stipulated by the Nursing Council and include a prescribing practicum. Rarely do nurses complete the master's programme within four years. Nurses are required to apply for annual funding and enrolment at the tertiary education of their choice.

### **Applying for funding: Layers of work**

In the scaffold map I have simply identified stage two as “apply for HWNZ funding through DHB”. I have included this example here as it shows how one seemingly straightforward work process is embedded in multiple text-work-text processes. Additionally, this process remains contentious and problematic for nurses today.



The primary informants in my study had experienced a range of funding models to support their tertiary education pathway. The Primary Health Care Strategy (A. King, 2001) had signalled the need to promote nursing's contribution to the health sector, and in 2003, the Clinical Training Agency (an office of the Ministry of Health) stated that funding would be directed towards 800-level programmes, providing nurses with a “stepping stone” towards NP status (Ministry of Health, 2004, p. 15). Further, in the mid 2000s, the Ministry of Health provided scholarships for primary health care nurses to undertake postgraduate education, including the Disease State Management course that Hannah completed. Other nationally or locally provided scholarships from a range of organisations are also available. In 2010, HWNZ replaced the Clinical Training Agency. (HWNZ is discussed further in chapter six, particularly in relation to physician assistants).

Receiving funding not only provides the monetary support for completing a clinical master's programme, but, as a text, affirms the value of postgraduate education, and the nurse's choice of career pathway. Leanne stated:

I got a scholarship from the Ministry of Health plus I got a scholarship from [name of local iwi] to complete my master's with prescribing and apply for NP registration. I had to complete that process.... Knowing I had support, that funding. Knowing I had support to complete the process. (Leanne)

The funding, both through the Ministry and the local Māori tribe (iwi), acted as a text supporting her to complete her master's and apply for registration as a NP. However, there are nurses who self-fund. In a survey of 500 nurses published last year (Carrier, 2016), 12% were declined HWNZ funding but continued to study, and a further 18% did not apply for funding. For the latter group, one of the main reasons given was lack of awareness of the availability of funding for postgraduate nursing education. The current cost of a single postgraduate paper is \$2242.38 for New Zealand domestic students<sup>42</sup>.

On the whole, the majority of nurses receive their funding through HWNZ. District health boards manage HWNZ funding for the postgraduate education of nurses through the offices of their DoN. It was evident through the interviews that different DHBs had different processes and supported primary health care nurses to varying extents. Liz stated:

Health Workforce New Zealand funding seems to be readily accessible to most people – priority is given to those already working in senior roles and to those who are already on their way to completing a particular qualification. (Liz)

Liz identified how, in part, the DHB was institutionally organising who was provided with funding. A NP candidate described how each year she would approach the nurse leader at

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<sup>42</sup> Cost of a core MN 30 credit 800 NZQA level course/paper at Massey University in 2017. NZQA is the New Zealand Qualifications Authority.

the DHB and apply for funding without any problems. She found the nurse leader extremely helpful in supporting her progress in a rural clinic. However, a NP candidate from a different DHB described how little support and information there was from her local DHB. She identified that there was no connection nor support between the DoN and the primary health care nurses. Regarding HWNZ funding she stated:

A flyer gets sent out once a year that the funding opens on a certain date and that they're going to have the different [tertiary] institutions' representatives down in the cafeteria or somewhere in the hospital for an hour or something. That's really how it works. Most people wouldn't have any clue how you actually start doing postgrad education, wouldn't even know where to start. (Natalie)

District health boards write their own texts, such as processes, forms, documents, advertising flyers, as well as determining who they will prioritise for HWNZ funding. Prior to HWNZ, the New Zealand Institute of Rural Health had enabled access to specific rural education, including the postgraduate diploma in advanced nursing – rural. In a survey in 2011, four of thirty responders (out of 79 graduates) had become NPs (Lancaster, 2011), and others may since have become registered.

Access for nurses to pursue postgraduate education in rural primary health care is variable across the country, and reliant on DHBs. Data from the biennial Nurse Practitioners New Zealand (NPNZ) survey (D. Williams, 2016) showed that there was considerable variation between the twenty DHBs of the numbers of NPs working in their districts. While HWNZ are a national office of the Ministry of Health and distribute funding to the DHBs, there is no overall strategic plan nor ownership at the national level for developing NPs in primary health care. Instead, DHBs develop and implement their own workforce plan, often enacting the texts and discourses that position acute hospital care as their priority.

The work processes for nurses and their employers engaged in applying for HWNZ funding are considerable. There is a complexity of text-work-text processes and ruling relations that organise the work of nurses. During my data collection period the HWNZ introduced a career plan template<sup>43</sup> that became a requirement for all applicants to complete (Ministry of Health, 2015a). The Ministry of Health stated:

No matter what stage you are at, a career plan helps you get the career and lifestyle you want. It also helps employers plan their workforce more effectively. (Ministry of Health, 2015a)

This authoritative text strongly coordinates the work of both the DHB staff who manage the funding process, the employers or managers who sign off the plan, and the nurses who complete the plan (annually). Nurses are now required by HWNZ to complete the career plan template. Under part one of the template, “Knowing yourself”, is the statement:

For an objective assessment, seek guidance from others as well. A discussion regarding your career aspirations, strengths and development needs during a performance review is regarded as a minimum.

The text requires a further work process - a performance review – to occur, which again is likely to be a complex series of text-work-text sequences, potentially requiring assessments from others, as well as forms to be filled, an appraisal, and completion/sign off forms and actions. In part four of the career plan “Make it happen” there is an agreed plan to be written up and signed off by both manager and applicant. The HWNZ form states:

You and your manager need to have a clear understanding of what steps you will be taking, the commitment needed by both you and your manager and relevant timeframes.

You are now ready to detail who has to do what to make things happen.

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<sup>43</sup> The career plan template is on the Ministry of Health website <http://www.health.govt.nz/our-work/health-workforce/career-planning>

While I am not commenting on whether the above processes are or are not valuable, I do want to draw attention to, firstly, the increasing work required by nurses on an annual basis to pursue their studies to become a NP; and secondly, the possibility of other discursively mediated texts entering into and being taken up by the manager and nurse. For example, the manager's ideas around nursing education and the future value to the practice; how to replace the nurse's clinical time while on study leave; equity amongst staff; and the worthiness of the nurse to pursue her career. In addition to the career plan, nurses also have to complete the DHB's own application form, informed by the specifications issued by HWNZ<sup>44</sup>. Again, it is likely that various texts will enter the decision-making of the Directors of Nursing (DoNs) who approve the application at DHB level. Their knowledge and interest in primary health care is likely to be a factor, as well as DHB health priorities and local workforce needs.

Many DHBs now require that nurses applying for funding are participating in a Professional Development and Recognition Programme (PDRP). Such programmes assess the continuing competence of individual nurses and maybe delivered by DHBs, PHOs, non-governmental organisations (NGOs), and other health providers. Nurses are required to submit a portfolio of evidence for assessment by the PDRP every three years. One nurse leader described that the process of completing a PDRP was an "important building block" to completing a NP portfolio. Again, I am not commenting on the value of the PDRP, nor on how the PDRP organises nurses' everyday lives. However, it is a significant work process, requiring evidence to be presented through, for example, peer reviews, self-assessment of competencies, case studies, audits, professional development activities, teaching, attestations from consumers/patients, assessment by manager, and reflective practice exemplars.

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<sup>44</sup> Postgraduate Nursing Training Specifications <http://www.health.govt.nz/our-work/health-workforce/investment-and-purchasing#nursing>

Access for primary health care nurses to PDRPs across New Zealand is variable, and reliant on the commitment of the PHOs, or the DHB to include primary health care nurses. One DoN interviewed for this study acknowledged that she did not know how many nurses in primary health care were participating in the DHB's PDRP, nor how many were pursuing postgraduate education. Apart from a very few DHB run primary health care clinics, most nurses working rurally in primary health care are employed by PHOs, Māori health providers, Trusts, or by general practices. The DoNs have direct accountability for DHB employed nurses, such as those in hospitals, or working with community services, including public health and district nursing, but their relationship with primary health care nursing is tenuous. The DoNs are employed by the DHBs and are members of the executive/leadership teams. Hospital activity and acute care remains the priority in health care budgets, and I would argue DoNs are likely to be more powerfully organised by the authoritative texts regarding DHB hospital services and spending, than by the longer term goals of delivering primary health care and, in particular, rural health services.

Having negotiated HWNZ funding (or not), nurses have to choose and enrol with a tertiary education institution. New Zealand has eight tertiary education institutions currently providing a master's programme that can lead to registration in the NP scope of practice, and a further two where nurses can complete their studies up to a postgraduate diploma. Several informants described the complexities they experienced in choosing which course (or paper) to undertake at the tertiary education institute. One rurally isolated NP described how she had received conflicting advice on what courses she was required to do and where. While the Nursing Council (2017b) have clarified the educational programme content there are still a range of choices the nurses need to make regarding order of courses, optional courses, and, of course, choice of provider. The process of navigating through a master's does require considerable work by nurses.

## Nursing leadership and support

Rural nurses are often isolated from their colleagues. The low number of registered NPs in rural primary health care has meant that nurses often have not experienced working with a NP. This, of course, is inevitable with the introduction of a new workforce role when they are, in essence, pioneers (Brown & Draye, 2003). The lack of such experience, however, was problematic for nurses as they worked to finalise their NP portfolios and be assessed by the Nursing Council.

I don't actually think you get a real understanding of the importance of the role and the level, the senior level of the role, if you don't have that collegial support and [the opportunity] of studying with a group that is going to carry you through that journey. (Carol)

Primary informants identified the value of having colleagues and nursing leadership, and acknowledged that completion of a Master's in Nursing was just another stepping stone. An experienced NP involved in mentoring others stated:

It's another ball game. They've finished their master's; phew, leave that behind. Now the next lot of hard work begins. And we're going to set you up ready for [the Nursing] Council. (Informant 3: Group 2014)

In a group interview, the NPs discussed how there were two distinct roles for support and mentoring:

Well are there two roles here? I mean the clinical oversight for making clinical decisions which a GP can absolutely do around case review; but then there's that other mentoring role around the leadership and the articulating of the nurse practitioner role, which maybe is not the GP - we don't look to GPs for that. We look to our colleagues (Informant 6, Group 2014)

Just some of the nurses, some inspirational nurse that you can sit down with, you can review “How do I manage this? Where am I going?” That leadership - I see that’s two quite different types of roles... (Informant 4, Group 2014)

Informants gave two examples of formal mentoring and support programmes provided. One PHO had identified a nurse leader who particularly supported nurses on their pathway from nurse to NP. This included helping with access to education pathways, HWNZ funding, requirements for NP portfolio, and support in accessing NP mentors. Jane described the support when she completed her portfolio:

And what drove [the portfolio] was the help through the PHO and the leadership group.... Then there was some funding available to help me to get a portfolio together. I suppose it was more like a semester again. There was a time frame with it and some goals. [The nurse leader] was put in place to be my mentor, I suppose my supervisor, to get me through to Nursing Council and that was the bit that made it happen. (Jane)

Another group reiterated the importance of both the PHO and the DHB’s DoN being involved in the process:

One thing that from the very time we started the NP [programme] was the effort to make the relationships that count, that were going to assist the nurse practitioner pathway, was really important. We’ve got the key stakeholders to me in this room. We do. We’ve got our PHO members... (Informant 5, Group 2014)

Our DoN. (Informant 6, Group 2014)

We’ve got our DoN. You know, she’s our DHB voice. (Informant 5, Group 2014)

She’s our mentor. She’s our... (Informant 6, Group 2014)

Champion. (Informant 1, Group 2014)

Yeah, champion. (Informant 6, Group 2014)

Champion for going into those areas and making the negotiations with people who develop the contracts with the DHBs. (Informant 5, Group 2014)

And we've got two clinical leaders in the PHO that absolutely support us and the NP pathway. (Informant 1, Group 2014)

The experiences of this group of NPs was in complete contrast to another NP candidate who described her support as "zilch" from both PHO and DHB.

A PHO chief executive officer (CEO) described the unfairness of the situation and how the environment differed considerably from one place to the next. She described the work that nurses intending to become NPs needed to do. She stated:

I'm aware of other places where it isn't as easy for a nurse practitioner to move through that whole pathway, because there is quite active sabotage of what's happening. You know you need the commitment of your employer, of your manager, you need a sense of where you're heading. You've got to really have an analysis of what you're doing and why you're doing it, you need to align with service goals and know where you fit in the scheme of things... You need to have conversations with key people, and you may need to talk to the Director of Nursing. It's complex. (PHO CEO)

The CEO went onto describe how she had aimed to create a culture of professional development, where nurses were supported to develop their career pathways in response to the population needs of their communities. The development of NPs for the PHO was a part of their strategic plan, and in turn this was supported by the DoN and the manager of the Planning and Funding team at the DHB. The result was that the PHO could appropriately use funding to provide mentorship for the nurses through to submission of their portfolio and attendance at the Nursing Council for their NP assessment panel. Further, they supported authorised NPs to share their knowledge with NP candidates to develop their own practice, and had established a successful NP forum.

When I asked the CEO essentially about how she managed the ruling relations and the variety of texts regarding NPs, she identified the report by the Ministerial Taskforce on Nursing (1998) as a significant text. She stated:

There was a group that actually brought together a whole lot of nurses from different areas of practice and organisational levels and talked about how to position nursing strongly, and there was a document that came out as a result of that group working together. This was a good document in terms of positioning nursing and nurse practitioners. So we took that and ran with it when we went back to our home ground. (PHO CEO)

Different individuals and organisations engage with and enact the same texts in different ways over many years. The CEO demonstrated how she gave power to those texts that promoted reducing health inequalities and developing the nursing and NP workforce over a fifteen-year period. She engaged with a social justice discourse and believed that all communities should have access to a NP. However other nurse leaders of PHOs and DHBs have failed to engage with the texts to establish a NP workforce. Instead, they have been subjected to other authoritative knowledge, including the necessity to continue the general practitioner-led model of care, discussed in the next chapter. Despite the availability of texts to advocate for the NP workforce, as well as the regulatory, educational, and legislative framework, there is no single text governing the implementation of the NP workforce in New Zealand.

## Liz's journey: The texts do not align

The Nurse Practitioners New Zealand (NPNZ) (2015) website states:

You can't guarantee a job **unless you have prepared the way**, and you can't do that in isolation, you must include people who can help with service delivery, funding strategies, business cases, job descriptions and team development. Becoming an NP is only one aspect of increasing the NP workforce, the workforce must also change shape to accommodate and embrace this new opportunity.

The advice instructs nurses on the activities they need to do in order to become a NP, and identifies that the health workforce must itself "change shape". This is the extraordinary tension that NPs experience. Firstly, the work processes behind each of these activities - service delivery, funding strategies, business cases, job descriptions and team development - is enormous, and requires the involvement of others. Evidence from research where change in practice is implemented identifies the commitment and time involved in supporting a team to make changes in practice (Belanger & Rodríguez, 2008; S. Morgan, Pullon, & McKinlay, 2015). Secondly, to be *accommodated* in practice requires not only practical changes to work processes, but also changes to the discourses regarding NPs delivering services that are at the very least equivalent to a general practitioner. Research has identified the necessity of an organisational climate that promotes collegiality and professional visibility to successfully implement NPs (Poghosyan, Nannini, & Clarke, 2013). Practice staff and patients are all required to accommodate the new workforce.

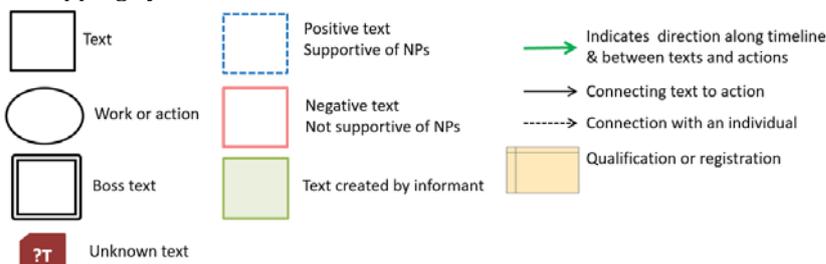
Liz was an advanced nurse, near to completing her master's and hoped to become a NP. She understood the necessity of working in a clinical setting that supported the development of NPs. Liz's journey over a three-year period is mapped.

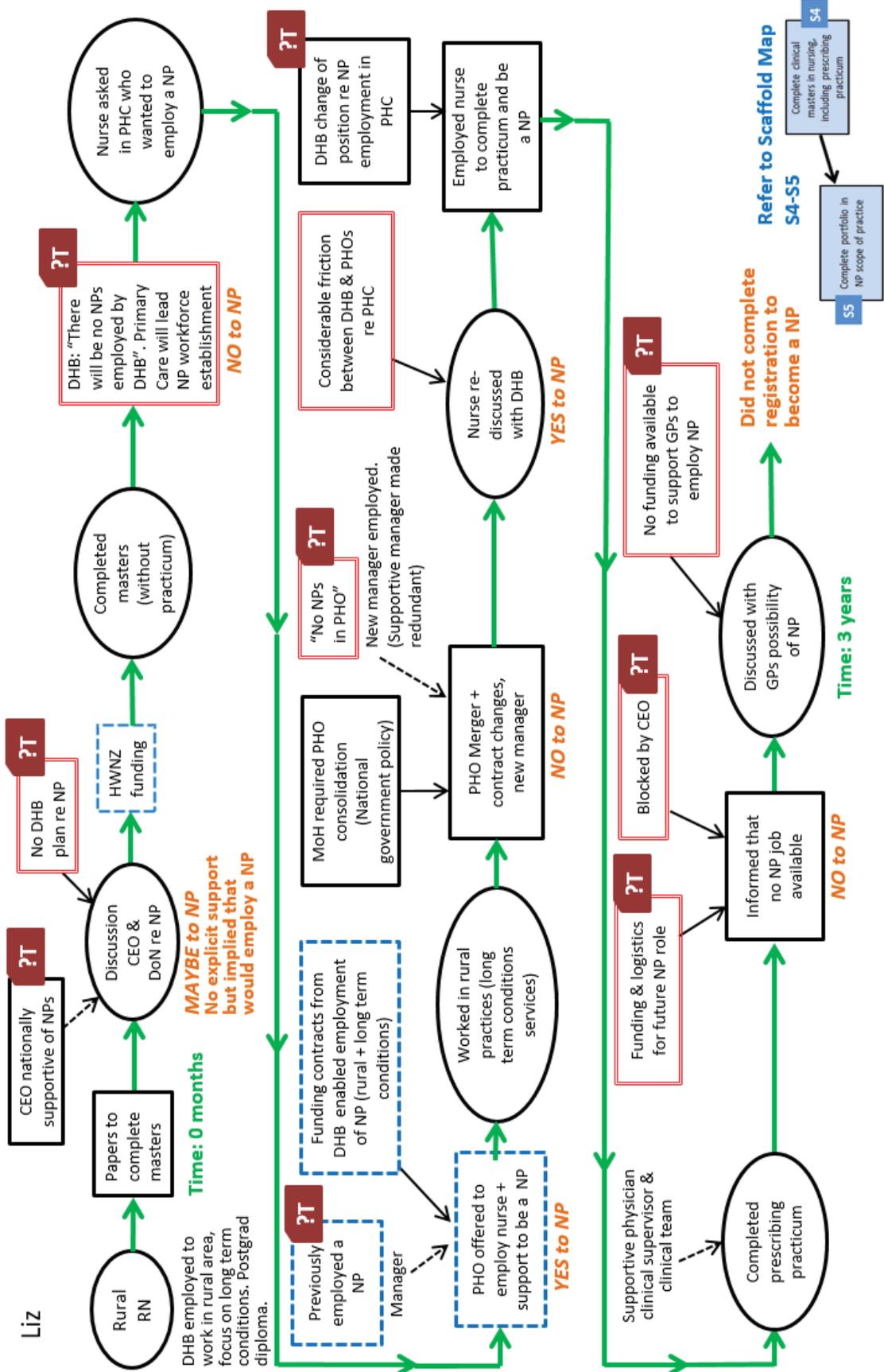
The map<sup>45</sup> (overleaf on page 164) shows the key actions that Liz took, and identifies some of the texts known to her that were organising her journey. Those texts that could not be identified at interview are marked with a “?”. The map portrays her efforts to gain employment in a position which would support her completing her master’s, prescribing practicum, and registering as a NP (S4-S5 of the scaffold map).

At the time shown as the start of the map, Liz was employed by the DHB to work with patients who had long term conditions and lived mostly rurally. She was an experienced, advanced nurse with a postgraduate diploma. She asked both the DoN and the CEO about the development of the NP workforce:

And I didn’t get a very clear answer that there was any kind of plan. There was a lot of talk about NPs coming in the future, and I think our CEO at the time was Chair of one of the NP Development Groups [nationally]. But no real guidance, so I shook my head and said “Well, I’ll carry on in long term conditions – politically for me, long term conditions seems to be the hot topic, that’s where the attention is, where the resources come in. That’s where the need in our community is – it’s not going to steer me wrong”, and so I continued on my pathway with long term conditions. By the time I was completing my master’s, probably finishing my thesis and about to start on my practicum, the DHB quite clearly said “No, we’re not looking at NPs in the DHB, we’re looking for Primary Care to lead the way”. (Liz)

<sup>45</sup> Mapping Symbols





Map 9: Liz: Three year journey

District health boards have a dual role both as a provider of secondary (and tertiary) health services, and as the planner and funder of primary health care services. Local PHOs are contracted by the DHBs through the PHO Services Agreement to deliver services including through general practices. However, the division of functions between PHOs and DHBs has often led to tension and the inability to implement population health strategies, such as reducing health inequalities (Cumming, Mays, & Gribben, 2008; Tenbensel, Cumming, Ashton, & Barnett, 2008).

Liz was unsure of the texts leading to this decision, though was aware of the tensions between the DHB and PHOs in the sector. She was somewhat bemused at the contradiction of the CEO's commitment at a national level to the NP project, yet those texts were not being enacted at a local level.

Liz searched to find a new position, where she would be supported to become a NP. She was offered a job by a manager of a PHO who had previously employed a NP, and who allocated rural and long term conditions funding to enable Liz's employment. Liz described the manager as:

Incredibly visionary, proactive, wanting the best for the community, and [she] felt that NPs and nurse-led services were the way forward. (Liz)

Liz established her work through rural general practices. However, a change in government policy resulted in a major restructure and consolidation of PHOs beginning in 2010, at the request of the Minister of Health, Tony Ryall<sup>46</sup>. The PHO, where Liz was employed, merged with another larger PHO, with its head offices out of the area. The result was that contracts were reviewed and a new manager employed. Liz lost her "champion", and was told that the PHO would not be in a position to support a NP. While Liz found that some general

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<sup>46</sup> The National-led government came to power in 2008 with a commitment to reduce health bureaucracy under the health policy *Better, Sooner, More Convenient* introduced by Tony Ryall.

practitioners seemed to be keen on employing a NP, the question was always “Where’s the money going to come from?”

Liz returned to the DHB. She was told by her DHB manager:

“We think that it [becoming a NP] is important. We’d like you to do it. Come on back and we can support you in your practicum and the rest of your pathway”. So I came back. I swapped my prescribing mentor for one of the physician’s here, and had a really great prescribing practicum. Then after a short period of time was told: “No, it [becoming a NP] is not going to happen. We’re not ready. Sorry.”

Liz was unsure exactly where this decision came from, but believed there was concern about the logistics of employing a NP and securing ongoing funding. She believed that the decision had been blocked by the CEO, who, at a national level, was seemingly an advocate for NPs. There was no change during this time to the national texts that described the need to develop the advanced nursing workforce and reduce health inequalities through primary health care provision. However, other texts were entering into the CEO’s local environment and being enacted instead, resulting in his change in decision. Textually, the CEO was giving priority to other texts and discourses. The hierarchy afforded to the texts in this complex climate was in a state of flux. Liz re-explored options to work in general practice, but there seemed to be no opportunities.

The excerpt from Liz’s map (p. 164) indicates the complexity of texts that are controlling the process, and her experiences and actions, many of which were outside of her awareness. The change around, or U-turns, in the policy of the employing organisations left her feeling “frustrated and disappointed”. Her embodied experience indicated a reality gap between the expected action of the organisation, the needs of the local community, and what actually happened. The overall message of the organisations are marked in orange text as ‘maybe’, ‘yes’, or ‘no’ to her becoming a NP within that organisation. However, she did recognise that

her NP pathway had been caught up in wider political issues, particularly through the National government policy requiring the consolidation (reducing the numbers) of PHOs:

I could see when we had [named] PHO in control of a lot of our practices, that NPs would have come, and would have come quicker in the practices, because we had someone innovative controlling the funding, and they would have been much more-able to say to the GPs “OK, I’m going to give you this funding, but I’ve ring-fenced it for the NP position; we’ll evaluate it as a model, and let’s see how you go”. And once they’d got it established, that would’ve been fine. Now that we’ve got such a disparate group of PHOs, the GPs have actually built up a kind of wall of resistance to anything new. It’s all changed so much, and they’re being managed by people from so far away, who don’t understand [our rural area] that they’ve almost built up this kind of barrier to further change. “We will do things at our pace, thank you, when we’re ready for them, and when it’s our idea.” (Liz)

Further, through the interview Liz recognised that the poor relationships between the PHOs and DHB had reduced the priority of establishing NPs in their area:

I feel like I did blame [the CEO] for the NP slow-down, and it’s true, it was his fault, but he is still trying to work on building relationships between primary and secondary care. (Liz)

Ultimately, Liz reflected:

I’ve never been bitter about what happened. I was frustrated at the time, but I’ve never been bitter about it because there’s absolutely no point in it in an area this size. If you get annoyed with the organisation you work for, there’s going to be nowhere else for you. So you learn to make your peace with it, and you move on. (Liz)

In her new position, Liz has continued to advocate for NP services in rural areas, and believes that increasingly the idea of NPs is being accepted by rural general practitioners. She is reconciled to not becoming a NP in the foreseeable future.

The map (shown on page 164) depicts a summary of Liz's journey. Each sequence of her journey would have been organised through multiple text-work-text sequences. However, by mapping in this way, the complexity of the frequently changing environment becomes visible, as well as how different texts are perhaps foregrounded at different times. Liz did a vast amount of work to prepare the way and endeavour to become a NP. She identified the unmet health needs of people with long term conditions living in a rural community and how NP services could address those needs. She proactively engaged with employers and managers who at the outset appeared to promote and be supportive of the NP workforce. She completed the clinical and educational work to meet the Nursing Council requirements to be registered as a NP. She has not yet become a NP.

## Summary

The journey to become a NP is arduous, requiring tenacity, dedication, and some luck. While it is perhaps an essential part of who those NPs are today, others, such as Liz, were subjected to frequent changes in policy, health service structures, organisational priorities, and the commitment of individuals. Through this chapter I have used data, mainly from the primary informants, to identify the key texts that were enacted by the RNs on their pathway to become a NP.

The scaffold map was used to show the pathway from RN to NP, identifying the key stages as described by the Nursing Council, tertiary education institutions, and HWNZ. What lies behind the scaffold map, as described by the primary informants, is a considerable work process to become registered as a NP, both for the development of their advanced clinical practice and decision-making, and their educational pathway in order to be in a position to apply to be registered as a NP.

The primary informants demonstrated how the ruling relations of rural health provision imposed an onus on nurses to provide a full range of primary health care services in isolated situations. In turn this has driven and organised their work and actions to become NPs. The nurses described their abilities to work within the system and engage with texts in a way that enabled them to provide services, although at times stretched the boundaries of their competence. Innovations in rural health, such as standing orders and PRIME, and working in out of hour's services, provided an opportunity for the nurses to work at the top of their RN scope of practice, further developing their advanced skills.

Alongside their clinical practice, the nurses were navigating their way through a clinical Master's in Nursing programme, including undertaking extensive work processes to apply for and secure funding on an annual basis. There is ad hoc access to HWNZ funding for primary health care nurses which is administered by the DoNs for each DHB. While I have not explored explicitly those texts organising the selection of nurses to fund for their postgraduate education, there is variation between the DHBs. It may be that some DoNs are more powerfully coordinated by the ruling relations organising service delivery within their own DHB services, rather than enacting the texts that advocate and regulate for primary health care NP workforce development.

The NPs identified how a nursing leadership discourse that supported the growth of NPs, whether through direct activities such as funding, mentoring, or professional development, enabled their progress to become a NP. The NPs recognised the actions and work of nurse leaders and managers at the PHO and DHB to establish such a robust infrastructure. For one particular PHO, it was evident that certain texts had been strongly engaged with and enacted, and while the CEO acknowledged difficulties over the fifteen-year journey, she determinedly drew on the texts advocating for a NP workforce, and reducing health inequalities.

Finally, I mapped Liz's journey as she repeatedly tried, though ultimately did not succeed in becoming a NP within her locality. The complexity of the health environment, and the multiple and frequently changing texts, was evident. There is no national policy regarding the implementation of NPs. Ultimately, the decision to develop the NP workforce is taken at a local level, whether DHB, PHO or local general practice. For RNs wanting to develop their practice there is an element of 'pot luck', and despite actions to ensure there is commitment from organisations, their success is dependent upon the alignment of texts supporting NP practice. The next chapter explores the contested space of general practice.

## Chapter Six

### The Contested Space of General Practice

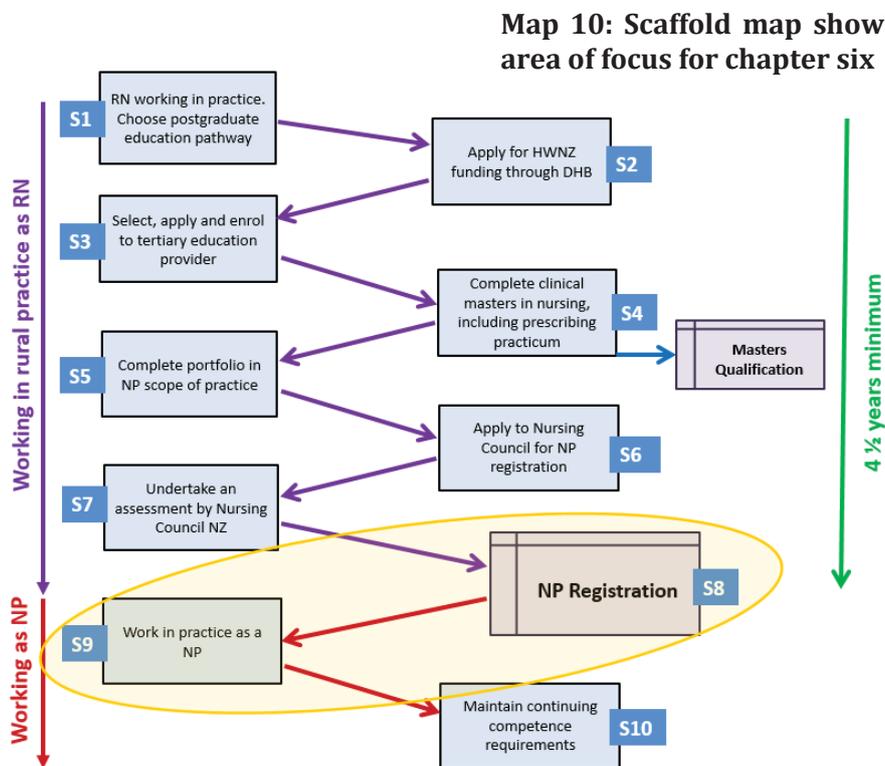
#### Introduction

Internationally, there is ongoing evidence that doctors are continuing to challenge the presence of NPs in primary health care (DesRoches et al., 2013; Naylor & Kurtzman, 2010; Poghosyan, Nannini, Stone, & Smaldone, 2013). Published in the *New England Journal of Medicine*, Donelan, DesRoches, Dittus, and Buerhaus (2013) wrote: “At the core of the controversy is whether NPs have the education and experience to provide high quality services and lead clinical practices without supervision by a physician” (p. 1899). The pervading discourse, that NPs’ ability to deliver primary health care services is inferior to doctors, is not supported by the literature (for example: Martínez-González et al., 2014; Newhouse et al., 2011; Swan et al., 2015). It would seem that there is more to the “core of the controversy” than Donelan and colleagues speak.

The tensions experienced by nurses and NPs, regarding their acceptance by doctors, have been identified through research in the US and Canada, where both countries have a comparatively long history of NPs (Poghosyan, Nannini, Stone, et al., 2013; Sangster-Gormley et al., 2011; Shea, 2015). The NP project in New Zealand began in earnest in 2001, and sixteen years later, tensions and arguments regarding the acceptance of NPs continue to be raised, predominantly through popular medical press and professional organisations’ publications and websites. Data collection from primary informants occurred between 2012 to 2015, and texts before and through this period would have entered the local situation. The power to rapidly reproduce and disseminate texts across multiple sites, without attending to evidence or rationale, has continued to promote the divisive discourse that NPs are in some way not acceptable in the primary health care workforce.

In chapter six I investigate the ruling relations governing the work that NPs, following registration, undertook to gain employment in general practices. Globally, and in contemporary health services in New Zealand, general practitioners are seen as the key and main provider of primary care services. Nurse practitioners are perceived as encroaching on this territory (McMurray, 2011; Poghosyan, Nannini, Stone, et al., 2013), yet health needs go unmet, and general practitioners themselves raise concerns about being overworked. This is the contested space of general practice.

The territory to be further explored and explicated is shown in the scaffold map.



The entry point to further data analysis and the tracing of texts begins from the tensions and disjunctures identified by the NPs and NP candidates. In chapter five I also wanted to show the texts that facilitated nurses to become NPs in their journey to become NPs, whereas here, in chapter six, I am concerned with discovering how the ruling relations work in concert to slow the growth of the NP workforce in general practice settings.

At a group discussion with NPs in 2014, the following was said:

We're not growing the nurse practitioner role in large numbers and I actually wondered whether we'd become just another big idea, and maybe somebody else will start to think "Is there a better way of doing things? Is there another model of care?" Do we become extinct before we even really get going? (Informant 7: 2014)

Strategically, I always thought that nurse practitioners would be in the primary health care sector and I firmly believe that that's where the focus needs to be. There is no doubt in my mind about that, because these roles are ideally suited to the population of New Zealand and primary health care. (Informant 3: 2014)

We are doing a disservice to our population by not having NPs. (Nurse Leader 1)

And particularly in rural communities... throughout New Zealand. There is no doubt about it. I mean I always thought that the predominance, the majority of nurse practitioners, would come into primary health care. (Informant 7: 2014)

This group of rural NPs and nurse leaders identified the appropriateness of their role and expressed concern about the slowness to become a significant workforce. Primary health care was defined in chapter one as based upon the principles of the Alma Ata agreement (WHO, 1988), whereas primary care was described as a subset of primary health care and responsible for general medical services. In the previous chapter I concluded with Liz's story, where she struggled to understand how a role that provided a service aimed at meeting the health needs of a deprived rural community was not embraced by the health sector.

The NPs had very different experiences and the work they had to do varied, reflecting the *ad hoc* process that Carryer et al. (2011) described. Smith (2005) notes that while texts and

discourses may themselves be contemporary, they are set within an historical trajectory. Nursing and medicine have often had an uneasy alliance that can be traced back through centuries of ruling relations (Group & Roberts, 2001). The colonisation of New Zealand in the mid nineteenth century through institutional regimes of law, justice, medicine, and education from the western world, and primarily from the British Empire, led to the establishment of medical dominance in health (Belgrave, 2012; Sargison, 2001). In this chapter I trace some of those historical texts that continue to organise health services and the work of the NPs.

The ongoing difficulties that NPs have in becoming a significant part of the general practice workforce are explored through two sections. The focus in the first section is on general practitioners in the practice setting who are resisting the development of the NP workforce; and in the second, on the work that the medical professional organisations do to maintain medical hegemony. Further, there are occasions where a change in health policy, or a new project, can threaten the development of the NP workforce. At the end of this chapter I describe the attempt to introduce the physician assistant role to the New Zealand workforce, including in rural areas. I call this a cautionary tale, which is used as an example of how authoritative texts can be rapidly rewritten to change the ruling relations.

## **The ownership of primary care by general practitioners**

The NPs interviewed for this study described the considerable work and effort undertaken to be employed in general practice, having completed their NP registration. While one NP, Jane, described a relatively smooth transition within a general practice environment (described further in chapter seven), for most, the transition was frustrating and demoralising, and required more work than they had anticipated. I did not interview any informants who were registered as a NP but not practising as a NP, and there is little data available in New Zealand to identify the extent of this issue. However, it was evident from

three interviews that it took a considerable time to move from authorisation as a NP to being employed as one. I begin this section by exploring the experiences of the NPs.

### **The disjunctures: “That’s what we’re up against”**

Elaine had continued to work as a practice nurse for six months after registering as a NP. The practice, despite supporting her to complete her Master’s in Nursing, was unwilling to employ her as a NP. She identified that the lead general practitioner was not supportive, nor willing to teach her or share knowledge.

I registered as a NP and I was working in a practice in [rural area] still as a practice nurse. It was a very difficult time there. That went on for six months until it became apparent that it was going nowhere. [GP from current practice] rang me up one day and he said “I want to work in a different way. Come and work for me”.... But I had a lot of learning to do in those early days, because I’d come from a practice where the GP principal wasn’t supportive. (Elaine)

Elaine joined this different practice where she has since been employed as a NP, and has been able to successfully implement NP services to the local community.

Natalie, a NP candidate in the process of completing her portfolio, had fully expected to be employed as a NP in the practice on registration. However, the practice recently changed ownership, with the older and supportive doctor selling out to a younger doctor. Natalie described one discussion with the new practice owner:

Well this is our GP who’s bought the practice and everything. [She said] “Oh well, you could do some sessions as a NP and then some sessions as a practice nurse”, and I said “No, no, I couldn’t do that because if I’m a NP, I’m a NP. How could you expect me to work as a practice nurse?” ... It’s like saying to her “Well you can come to work one day and work as a GP, but these other days you have to work as a trainee intern.” I mean she wouldn’t

work like that would she? It's just like you're either a NP or you're not, you know? (Natalie)

Both Elaine and Natalie described how despite their authorisation as NPs the general practitioner owners expected they could remain as RNs working in the practice. Instead of now focusing on completing her portfolio, Natalie said she was "laying low at the moment", and wondering where to go to next. She said:

[I]n general practice the GPs traditionally don't want to use any of their income to give to their nurses.... The GP owners are not willing to take [me on] because - and I know it for a fact, because I was talking to a GP one day and I forget what it was around, but it was sort of to do with like funding his nurses more to do something. He said "No way. My kids are not going to get less in my retirement because I'm going to pay my nurses more". (Natalie)

Natalie, following a change in general practice ownership, became employed by a general practitioner who was not prepared to recognise how Natalie could work and add value as a NP within the practice. This about turn for Natalie was frustrating, and she stated:

But that's GP owners. That's the paradigm. That's what we're up against. (Natalie)

She had previously felt strongly supported and accepted by the previous general practitioner owners. This had suddenly changed. The disappointment was palpable throughout Natalie's interview. She had prepared the way for employment as recommended by NPNZ, yet a change in circumstance beyond her control had resulted in her needing to find a new practice and employer, should she wish to continue on to be a NP. The visible discourses for Natalie were money and the lack of willingness of the general practitioner owner to invest in nurses who could provide an alternative model of care to meet patient needs. She experienced frustration that a single general practitioner, now the owner of the practice, could not understand her potential work as a NP, particularly given the previous general practitioner owners' commitment to her progression as a NP. Her

engagement with the texts and discourses had left her with a sense of powerlessness and lack of direction. She believed that a model where health providers directly employed general practitioners, rather than a general practitioner ownership model, would enable NPs to more easily become established. Nurses in general practices often remain unaware that the majority of a general practice's income is through public funding (discussed later in the chapter). However, as owners of the practice, general practitioners assume control of all of the incoming funds and retain the right to determine how others practice in their business.

Other NPs had similar experiences. Ellie identified one of the two general practitioners she worked with as being 'negative' toward NPs. Ellie believed this was because the general practitioner thought that Ellie would take her patients and potentially leave the general practitioner without work. While the two part-time general practitioners were employed in the DHB clinic in which Ellie worked, she identified that the general practitioner experienced a tension in 'sharing' the workload of the practice with the NP.

Shona described a time when she was asked to provide locum cover at a practice by the DHB, but the general practitioners objected to having a NP:

At one stage the [small town] medical practice was really short of doctors, and we had lots of capacity in [our area] at the time, and the managers suggested I go up there and work at [the medical practice as a NP locum]. ... I thought I'd have to talk to the doctors, I didn't want them to be unhappy about me coming. They were very nice face to face, and then they told the managers that if I went to work there they would all leave. (Shona)

However, over time, this situation changed and Shona has since returned to locum at the practice. She explained that this was as a result of "word of mouth", spread by general practitioners who had worked with her, including a general practitioner who has advocated for the NP workforce in his local area.

Alana was working as a NP in a satellite clinic where the general practitioner owner attended one day per week. She was self-employed with no allowance for professional development, peer supervision, travel, sick or annual leave. Her salary was low. Despite the support from the general practitioner to contract her, she believed that ultimately the focus was on the practice as a small business and that there were considerable tensions and mixed messages:

I reckon [the GP] tries to present me to patients as a doctor. That's what I reckon... I reckon it's easier for him. He says "You're just like a doctor", and I say "I'm so not like a doctor". In fact, one day I had the pleasure of someone calling me "doctor" in front of him. I said "Ooh, don't say that, that's an insult!" Do they have any idea how much you don't want to be a doctor.... I think underneath that he doesn't truly believe that if there was a choice between doctors and nurses, the patient wouldn't choose a doctor.... And I reckon he tries to sell me as a doctor in order to get patients to join the practice. What he doesn't realise is the one thing they'll always say is we love you because you're not a doctor. (Alana)

Alana clearly identified that a NP works from a different model of care, and that this has caused tension between her and the general practitioner. Further, she is describing how the need for the practice to make a profit was driving the actions of the general practitioner practice. The general practitioner owned two practices at some distance apart, and given the lack of availability of general practitioners in the area chose to employ a NP. As discussed in chapter five, the reduced general practitioner workforce provided an opportunity for the NP to establish comprehensive primary health care services autonomously.

During a group interview, NPs discussed how some general practitioners did not want to give up their 'easier' work:

A bit like the GP who said [to me] “I like doing the hypertension checks. It’s really easy, it’s really simple and I just repeat prescribe and we chat about something else” and it’s not challenging. (Informant 2)

Simple as. (Informant 4)

They [the GPs] like long term condition patients. That’s why there’s a little bit of trouble with long term condition patients. The GPs don’t want to give them up. It’s their bread and butter, and it’s easy. (Informant 5)

Like repeat prescribing “Come in, oh yes, you’re all up-to-date. Everything going OK? Blood pressure – yeah – very good”. And the patient likes it too.

It’s like talking to an old mate. (Informant 6)

The NPs identified that general practitioners were unwilling to give up some of their easier and less challenging work, such as the repeat prescribing of medications, and reviewing patients with long term conditions. The NPs themselves identified that at times it was great for them to also do some of those “more simple” tasks, such as cervical smears and injections. However, the concern is that many patients struggle to access primary care services, particularly in rural areas. When general practitioners hold onto patients that could be managed by either RNs or NPs, this further limits the availability of services and does not make appropriate use of the health workforce. This is contrary to the *Better, Sooner, More Convenient* national health policy (Ryall, 2007) that stipulated value for money services provided by the right person, at the right time, in the right place.

The data from the above interviews illustrates a variety of tensions experienced by the NPs and NP candidates interviewed. They identify discourses that concern money, business and profit, and practice ownership. They describe how they might be encroaching on the general practitioners’ territory to provide services, potentially leaving general practitioners without work. Furthermore, the NPs expressed their belief that general practitioners were concerned that NPs may take their more straightforward primary care work, leaving the general practitioners with a more complex and time-consuming workload. The following

sections explore the ruling relations from the primary informants' tensions and disjunctures experienced and described above.

### **General practitioner owned general practice: The historical texts**

The general practice ownership model has limited the development of advanced practice nursing (Finlayson, Sheridan, Cumming, & Fowler, 2012; Gauld, 2009; Wilkinson, 2007). Natalie, when she stated, "But that's GP owners. That's the paradigm. That's what we're up against" was referring to how the historically located model of general practice ownership restricted her advancement as a NP. She felt powerless within the system, and identified that her potential to become a NP relied upon the perspectives of the individual general practitioners. Beginning from the standpoint of the primary informants, I explore those historical texts that have perpetuated the ownership model of general practice, and remain as a powerful ruling discourse today.

The health care system in New Zealand remains a dual or hybridised system where hospital services are free of charge, while general practice services have user co-payments. Other third sector organisations (neither governmental nor private), such as well child providers, community trusts, and Māori health providers, generally have no or low charges. Through to the 1980s, general practitioners functioned largely independently, receiving subsidies under the General Medical Services scheme of 1941 (Quin, 2009). They operated as private practices charging fees to patients and referring patients through to publicly provided hospital and community services.

General practitioners, through the New Zealand Medical Association (NZMA), had previously rejected the opportunity to provide free and universally available primary care services under the Social Security Act of 1938 (Gauld, 2009). In a recent report to the Minister of Health the rationale given for the opposition to the 1938 Act was that a "universal service was unnecessary since many people were able to pay for services themselves" (Primary Care Working Group, 2015). Instead, an agreement was made that

the NZMA would informally ensure user fees were kept at a reasonable level (Quin, 2009). As a result of the “power and opposition of the medical profession” (Gauld, 2009, p. 15) a very different health policy structure emerged and a significant opportunity was lost to provide free primary health care for the whole population, including for Māori.

Through the 1970s there was increasing commentary, including in the *New Zealand Medical Journal*, about the health of Māori in New Zealand (Dow, 1995). Health statistics produced annually in the *New Zealand Official Yearbooks* (since 1893), identified the “comparatively poor state of health” (for example: Statistics New Zealand, 1969) for Māori across health measures including infant mortality, diseases, accidents, and life expectancy, though the gaps appeared to be reducing (Rose, 1972). In the mid to late 1980s, the Labour-led government made attempts to reduce user charges by negotiating formal contracts with general practitioners to give higher state subsidies in return for reduced patient fees. These proposals were again resisted by general practitioners through the NZMA (Barnett & Barnett, 2004). The tension is evident between the purpose of a general practitioner service and the actions of the NZMA to ensure that general practitioners’ position and income is maintained.

While neoliberal policy was introduced during the mid to late 1980s by the Labour-led Government (Gauld, 2009), it was in the 1990s that the newly elected National Government began comprehensively restructuring the health sector. A competitive, quasi-market approach was implemented where commissioning authorities<sup>47</sup> were given the responsibility to purchase primary care services (Quin, 2009). New Public Management, with the introduction of general managerialism, eroded the leadership of both doctors and nurses particularly within the hospital sector. The enrolment of patients by general practitioners was a precursor to shift funding to population-based primary care. The

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<sup>47</sup> The commissioning authorities were initially four regional health authorities (RHAs) in 1993 and later merged to form one single Health Funding Agency (HFA) in 1997

intention was that through a system of capitation<sup>48</sup> (with continued fee-for service) and budget-holding, a more equitable funding model would be established across the country, with improved health outcomes and reduced health inequalities (Crampton, 2001; Upton, 1991). However, by 1997 only 15.1% of general practitioners were taking capitation funding (Ministry of Health, 1998), again demonstrating their resistance to providing primary care at a reduced cost to users.

The health reforms of the 1990s were considered the most radical of any public health sector restructuring across the world (Davis & Ashton, 2001; Gauld, 2009). The radical restructuring was critiqued in *The New Zealand Experiment* (Kelsey, 1995) and internationally because of New Zealand's "reputation as a social democratic, welfare state that went neoliberal with a vengeance" (Peet, 2012, p. 151). In 1999 a new Labour-led coalition was elected that commenced another major health reform (Cumming, 2016). The introduction of the Primary Health Care Strategy (A. King, 2001) had clear aims to strengthen the role of primary health care in order to improve access and quality of health services, address causes of poor health status, and reduce health inequalities. The policy context changed with the new government fostering cooperative rather than competitive models of health care (Barnett & Barnett, 2004).

The Primary Health Care Strategy enabled the creation of primary health organisations (PHOs) as not-for-profit non-governmental organisations (A. King, 2001). A system of capitation funding based on the enrolled population was introduced accessed by general practices who were members of the PHO. Further funding was made available to PHOs for use in their local communities, such as for services to improve access, particularly for high

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<sup>48</sup> Capitation payments are based on a payment per capita (head) of people enrolled at a general practice. The formula is based upon age group and demographics. Capitation rates are published on the Ministry of Health website, and included in PHO Services Agreement between the DHB and PHO contracted annually. Children under 13 years old are now entitled to free visits to the general practice and no charges on prescription items. For all other age groups, a fee for service is charged by the general practice. Across the country general practitioner fees range per adult from \$15 to \$65 per consultation, depending on capitation rates and other funding sources.

needs populations, health promotion, rural health funding, and funding to support the management of long term conditions. This time round, the majority of general practices accepted the offer of capitation and joined a PHO. Capitation funding incorporated the Practice Nurse Subsidy, previously available for general practices, and was anticipated to be a way of funding nurses in general practices (Wilkinson, 2007).

The Strategy signalled a “move beyond general practitioner-driven, fee-for-service, individually focused care” (Finlayson et al., 2012, p. 121) towards a population health approach by developing the primary health care workforce to work in a coordinated way with local communities and enrolled populations. There was a strong emphasis throughout the document on the role of nurses in general practice, and other community settings, including well-child services, and Māori and Pacific health providers. Further, nurse leaders, nurses, and policy makers, including Annette King, the Minister of Health, saw the Strategy as an opportunity to develop NPs. She stated:

The vision for the Primary Health Care Strategy includes the development of a high-quality workforce, a focus on better health for the whole population, and a reduction in health inequalities between different groups... [P]rimary health care nursing will be critical to the implementation of the strategy, and nurse practitioners are ideally placed to provide many of the programmes and services needed to achieve these objectives. (Foreword by Annette King, in F Hughes & Carryer, 2002, p. iii)

Yet while the intent of the Strategy was within a social welfare paradigm, the existing model of general practitioner-led primary health care continued to dominate. The creation of PHOs across the country was inconsistent and ungoverned, with many PHOs formed from networks of general practitioners that had been established as a consequence of the health reforms in the 1990s. These Independent Practitioner Associations (IPAs) with shareholding general practitioners provided administrative and business functions to the PHOs. In essence little changed in either structure or goals (Finlayson et al., 2012), undermining

the ethos of the Strategy. The majority of PHOs, and their general practices, continued to provide general practitioner-led care with higher than expected user payments and a focus on individuals rather than populations (Cumming et al., 2008; Finlayson et al., 2012).

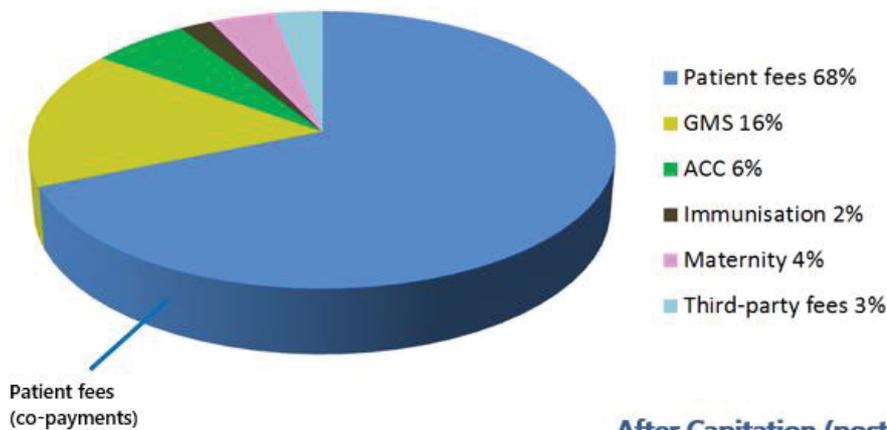
In late 2008 a new National-led government was elected with a change in health policy direction (Ryall, 2007). New Zealand health policy is discussed further in chapter seven, however, it is worth noting here the significance placed in the policy document on general practitioners: “GP surgeries...; GPs with special interests...; GPs in emergency departments...; Specialist assessments by GPs...;” and finally for primary care funding “Universal subsidies for GP visits” (Ryall, 2007, p. 4). *General practice* is written in full, hence it can be assumed that *GP* did mean *general practitioner*. Conversely, nurses were given two mentions on the same page: “Specially trained nurses ... involved in chronic care” and, in relation to integrated family health centres, “increased nursing” (Ryall, p. 4). There was no mention of NPs in the 51-page document. The policy document (Ryall, 2007) reaffirmed the position of general practitioners in primary care, whereas the previous Labour Government’s Primary Health Care Strategy (A. King, 2001) had promoted primary *health* care, endorsing different delivery models and the increasing role and scopes of nursing. By remaining largely unrecognised institutionally through Government policy, nurses’ capacity to contribute their knowledge to the health of communities was being undermined (Rankin, 2015).

The election of the National-led government, during the global economic crisis, resulted in a return to neoliberal government policies where responsibilities are devolved away from central government, bureaucracy and spending reduced, the growth of the private sector encouraged, and small business supported. Neoliberalism has been identified as being “bad for our health” (Mooney, 2012). However, during this period, there have been various legislative changes that have supported NPs to be autonomous practitioners, registering patients, and enabling them to run their own practices. As with general practitioners, NPs

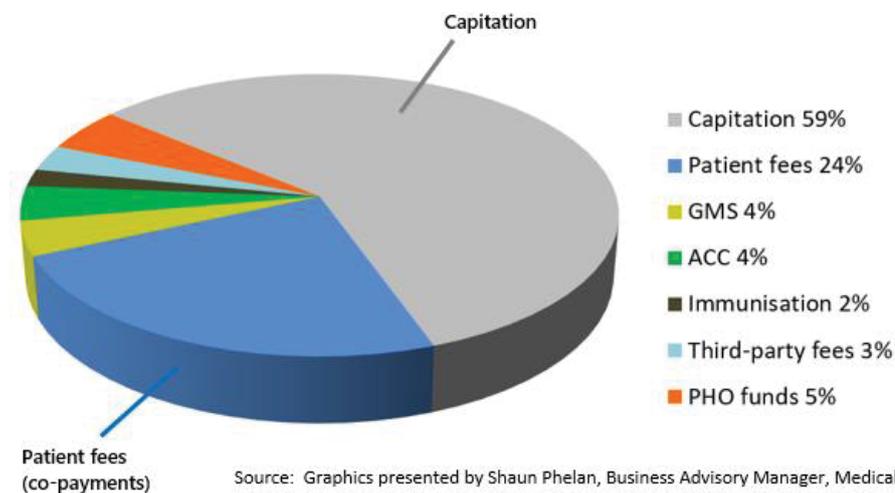
receive funding through PHOs for capitation, and a range of other services. Additionally, changes to general practice funding since the introduction of the Primary Health Care Strategy, has reduced patient fees from 68% to 24% of funding, with 59% of practice income now coming from capitation. The figure below shows the changes to general practice income since the introduction of capitation payments in 2001 (Topham-Kindley, 2015).

**Figure 5: Changes to general practice income since the introduction of capitation**

**Before Capitation (pre 2001)**



**After Capitation (post 2001)**



Source: Graphics presented by Shaun Phelan, Business Advisory Manager, Medical Assurance Society. Reprinted with permission: NZ Doctor, 16<sup>th</sup> Sept, 2015. (Topham-Kindley, 2015)

Yet despite a funding model that should support nurses and NPs working in practice, the “ownership model” of general practice by general practitioners continues to be a powerful ruling relation that maintains medicine’s hegemonic position in primary health care.

## The resistance bloggers

Over the years various highly influential medical leaders have challenged the value, use and necessity of the NP role within New Zealand (Gorman, 2009; Moller & Begg, 2005; Peterson, 2015). Debate ensues, often through the medium of New Zealand Doctor. This magazine published fortnightly, and online, is a 'niche' publication with 2500 subscribers. Of these, 2000 are general practitioners, with the remainder from the wider health sector, including Ministry of Health and DHBs; and 85% of general practices receive a copy (Mickell, 2016, personal email communication). Comments responding to articles on NPs, concerning funding, legislative changes, and workforce development, are often toxic, and uninformed. For example, 'Coalface' (an anonymous subscriber) wrote:

Most NPs/wannabe NPs I have worked with in a community setting were dangerous. They didn't know, and yet thought they knew it all. Grasp far exceeded reach. Prescribing just scared me, insight little. Experience of prescribing safely for years before independent practice non existent. [sic] (Docherty, 2014, see comment by 'Coalface')

'Coalface', whom we can presume is a general practitioner, deliberately and falsely leads the reader. He/she cannot have worked with as many NPs as implied, given the current numbers of NPs, and NP candidates in the country. The words 'dangerous' and 'scared me' bear no relation to the international evidence. Yet such comments are allowed to pass unremarked by medical organisations and ministry officials.

Bill Douglas, general practitioner, another regular commentator and blogger in New Zealand Doctor, stated:

The real problem with this huge influx of "literally thousands" of [nurse] practitioners being released on the cosseted fields of the brave new health scene is that many will have social theses as the basis of their masters training not scientific knowledge and as well there may be many who may not know what they do not know. By then Pandora's box will be long opened

and many furries will have been released. (P. Wilson, 2015, see comment by Bill Douglas)

Bill Douglas' comment on "scientific knowledge" claims that NPs do not have the required knowledge from the scientific paradigm of medicine to practice safely, because they "may not know what they do not know". The strength of NP education is that it utilises positivist scientific knowledge for pathophysiology, pharmacology, assessment, and prescribing, and draws on social and psychological sciences for responding to the complexities of individual and community health needs within a social justice framework (Browne & Tarlier, 2008; Budzi et al., 2010; Stewart, 2016). It would seem that Douglas is endeavouring to hold onto the privileged position of medicine, discounting others.

On the release of a New Zealand study (Pirret, 2013) where no statistically significant difference was found between the diagnostic reasoning of NPs and medical registrars, Jon Wilcox, a general practitioner, and again frequent commentator in New Zealand Doctor, stated:

This study is a bit of a sham really. Any good triage nurse working at an A&M clinic would also get the same results as 'a Registrar' or a 'GP' or a 'whatever' in this particular study.... We need NPs in primary care (where are they all ??) but we do not need sham research and we do not need clinical 'empire building'. We have a lot of hospital initiatives with nurse specialists (a better term).... [I]n primary care they don't seem interested - presumably there is insufficient prestige in primary care 'specialist' nursing. (A. Cameron, 2014, comment by Jon Wilcox)

Firstly, it is of interest to note how Wilcox dismissed the research, twice using the term 'sham' without foundation. The research has since been published in the International Journal of Nursing Studies (Pirret et al., 2015), one of nursing's highest ranked journals on SCImago (SCImago, 2014). Pirret's research was within the positivist scientific paradigm, quantifying diagnostic reasoning within a biomedical framework, and yet was disparaged.

Secondly, Wilcox evidently failed to understand the scope of NP work, referring to ‘specialist’ nursing. As with Douglas, the intent of the comments appeared to be resisting the development of NPs as a viable workforce.

## **Resistance from medical professional organisations: Moving up the chain of command**

To further explore the institutional origin of the texts that were informing general practitioners’ lack of acceptance of NPs, I shall begin with a text published in 2009. This text, and the engagement with it by at least some general practitioners, is evident through the primary informants’ experiences, and by the quotes from general practitioners cited above in *New Zealand Doctor*. The arguments presented in this text are taken up and have been repeated by medical organisations through to the time of writing this thesis. The writers of the texts are themselves coordinated by international medical organisation texts.

In 2009, a debate was published in the *Journal of Primary Health Care*<sup>49</sup>, a New Zealand publication, entitled *The NP provides a substantive opportunity for task substitution* (Gilmer & Smith, 2009; Gorman, 2009). Des Gorman, who at that time was Head of the School of Medicine at the University of Auckland, argued “no” to the statement. Gorman stated:

The moot that NPs provide a substantive opportunity for task substitution in primary health care in New Zealand is not borne out by experience and is potentially in conflict with a fundamental objective of most health service planning, which is that primary health care and/or general scopes of practice become the usual habitat of doctors. (Gorman, 2009, p. 142)

Gorman agreed that NPs did have a place in the health workforce. However, he commented that there was “no data to show cost- or outcome-efficacy for a non-doctor patient

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<sup>49</sup> The *Journal of Primary Health Care* is published by the Royal New Zealand College of General Practitioners

differentiation role” (p. 143). He argued that more, rather than fewer, doctors were needed on the front line of health care, with the implication that NPs were not able to take on the role of diagnosing and treating patients in primary health care.

At the time of the article, Gorman (2009) pointed out that there were just fifteen NPs in primary health care. He stated: “This reality illustrates the extent to which the architects of the PHCS [Primary Health Care Strategy] engaged in ‘magical’ thinking” (p. 142). Immediately following the reference to “magical”, he stated:

In contrast to a common obsession that employment models limit NP engagement, qualitatively the barriers would appear to include GP and consumer attitudes, a sense amongst nurses that the required training to become a NP is onerous and time-punitive, a strong desire among nurses to maintain part-time work that accommodates their own and their family needs, and an apparent reluctance to accept roles that result in significant clinical responsibility. (Gorman, 2009, p. 142)

The discourses evident through the above quoted sections from Gorman include that doctors are the most important providers of primary health care; that neither doctors nor patients will accept NPs; and that nursing is a gendered occupation (rather than profession) where nurses (assumed to be women) are content to work in subordinate positions. Gorman’s position exemplifies the rationale for Dorothy Smith’s critique and rejection of mainstream sociology where women’s experiences are conceptualised from a masculine standpoint of ruling and privilege (Smith, 1987). Gorman has demonstrated how he has written from the position of an outside observer and created a discourse where the social phenomena (nurses as part-timers, not committed) are in turn interpreted as social facts. He is articulating the ongoing hierarchical and historically patriarchal position held by medicine resulting in the marginalisation of the nursing workforce (Fletcher, 2006; Group & Roberts, 2001).

In August 2009, just two months after the publication of the NP debate (Gorman, 2009), Gorman was appointed executive chair of the newly created Health Workforce New Zealand (HWNZ), responsible to the Ministry of Health for the planning and development of the health workforce. Four years later in 2013, Gorman voiced his “disappointment” that the nursing professions had themselves expressed disappointment with HWNZ’s performance and lack of focus on the nursing workforce, instead blaming the nursing champions group for failing to do their job (Nursing Review, 2013a, 2013c). While HWNZ had schemes to promote nursing, midwifery, pharmacy, and other health professional workforces, priorities and funding continued to be targeted towards the medical professions. Of the \$165 million for 2013-2014 financial year, 66% was for medical related schemes, and 11% for nursing (Ministry of Health, 2014e). Yet there are over three times more nurses than doctors in New Zealand (Medical Council of New Zealand, 2014; Nursing Council of New Zealand, 2014a). General practitioner training was funded \$19 million, an amount similar to the HWNZ funding for the entire nursing workforce (Ministry of Health, 2014e; C. Taylor, 2014). Yet establishing the NP workforce was not identified as a priority. Additionally, in the years between 2013 and 2015, HWNZ funded a rural physician assistant scheme, employing seven PAs across four demonstration sites at a cost of \$1.2 million (Appleton-Dyer et al., 2015; Cassie, 2015) (see later in this chapter).

With lobbying from the professional nursing and midwifery organisations (Nursing Review, 2013c) Gorman began to change his public rhetoric regarding NPs. He stated:

The NP, which I think is absolutely an essential and sensible model of care, has never had the traction in this country it deserves because the employers saw them as being too expensive and too long to train.... Some innovations fail because you are disrupting a powerful lobby group or guild that chews you to death. GPs, for example, so you’ve got to make sure you get the potentially most disruptive people on board. (Nursing Review, 2013b)

However, there is little evidence to indicate that Gorman, or HWNZ are undertaking any work to get the “disruptive people” on board, nor to challenge any myths or misconceptions, such as the expense of training, and dogmas that Gorman himself presented in 2009.

Similar arguments are now being taken up by the New Zealand Medical Association (NZMA). The NZMA has a membership of approximately 5,500 doctors and, it seems, the majority of the country’s just over 3,100 general practitioners belong to this organisation (Ministry of Health, 2014c; New Zealand Medical Association, 2016, phone call). In a response to the recent consultation on the scope of practice and qualifications for NPs (Nursing Council of New Zealand, 2014b), Stephen Child, chair of the NZMA was quoted as saying:

“Nurse practitioners are an important part of the healthcare team, but they cannot substitute for a fully trained doctor, particularly where the diagnosis of complex medical conditions is concerned.” [The expanded scope and newly developed competencies could] “inadvertently undermine the Nursing Council’s primary role under statute to protect the safety of the public”. (Lee, 2015, Dec 17, quoting Stephen Child)

Child’s response was published in *New Zealand Doctor*. Child brings to the fore the misleading connection between NP competency and public safety, a response commonly given by organised medicine (Group & Roberts, 2001), also evident in Donelan et al.’s (2013) article cited at the start of this chapter. Neither the Ministry of Health, nor HWNZ have publicly corrected Child.

Tracing through the texts, Child is drawing on a letter submitted by the NZMA to Carolyn Reed, chief executive of the Nursing Council of New Zealand on 26 Feb, 2015, on the NP scope of practice consultation. Indeed, Child expressed his “disappointment” that the Nursing Council had not addressed the issues raised in the NZMA letter. In doing so, Child reactivated this text, and the discourses contained within it, placing it firmly back in the domain of general practice. Two months later Child again commented on the consultation

(Lee, 2016, Feb 3). On this occasion, he challenged a NP's ability to work with people with comorbidities, such as chronic obstructive disease and diabetes, though acknowledged they were an important part of the healthcare team.

The letter referred to by Child (Lee, 2015) was written by Mark Peterson, who gave feedback on the proposed new scope of practice for NPs on 26<sup>th</sup> February, 2015 (Peterson, 2015, see Appendix G for entire letter). The letter is available on the NZMA website. Peterson was Child's predecessor as chair of the NZMA. Peterson phrased the letter within concerns of the risk of NPs undertaking 'independent practice', outside of a general practitioner-led practice. The letter begins by dismissing general practitioner workforce issues, and, in common with Gorman (2009), suggests that nursing organisations should focus on the predicted shortfall of RNs by 2035, and not on expanding the scope of NP practice. However, recent data indicates that growth in the nursing workforce is now aligned with population growth, and the predicted shortage of RNs by 2035 is now less likely (Office of the Chief Nursing Officer, 2016).

While citing nursing figures, Peterson failed to present figures for the predicted global and New Zealand doctor shortages (OECD, 2013). Just two months before Peterson's (2015) letter to Nursing Council, the *Health of the Health Workforce* report (Ministry of Health, 2014c) was released identifying that general practitioners were one of New Zealand's critical workforce shortages. Indeed, this led Gorman to state that the doctor shortage in general practice was HWNZ's "number one" priority (New Zealand Doctor, 2014). Gorman, again, demonstrated his belief that the solution to the primary health care workforce issue resided with doctors. Peterson, however, simply ignored these statistics.

The NZMA letter continued, identifying the risk to patient safety in the context of broadening the area of practice of NPs, leaving them potentially working "autonomously and independently rather than collaboratively" (Peterson, 2015, p. 2). Such a statement makes no consideration of the health needs of the population. Rurally, areas of deprivation

are likely to have reduced access to community resources, including health care (Pearce et al., 2008). Given the levels of health inequality, broadening the area of practice is necessary, in order for NPs to provide health care for all whānau across the lifespan. It would appear that Peterson was not considering solutions to improve patient access to health care services.

Paragraph six of the NZMA letter identified further reservations regarding NPs and the diagnosis of complex medical conditions (the wording as used by Child above). At this juncture, Peterson referred to the Consensus Statement on the Role of the Doctor (New Zealand Medical Association, 2011), endorsed by fourteen organisations, where diagnosis was stated as a key feature of a doctor's expertise and "that doctors must take ultimate responsibility for medical decisions and diagnoses in situations of complexity". Of the fourteen organisations, only the New Zealand Rural General Practice Network had nursing membership. All others were solely medical organisations<sup>50</sup>.

The final paragraphs of the letter established medicine in its historically located position of leadership and authority:

We welcome the Nursing Council's proposal to remove the statement on clinical leadership... It is our view that doctors are in the best position to assume the role of clinical leadership in multidisciplinary teams. (Peterson, 2015, p. 3)

In fact, the term "clinical leaders" remained in the scope of practice for NPs following the completion of the consultation process (Nursing Council of New Zealand, 2017c). The

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<sup>50</sup> NZMA (2011) Consensus Statement On Role Of The Doctor endorsed by: The New Zealand Medical Association, Cardiac Society of Australia and New Zealand (NZ Branch), Royal Australian and NZ College of Psychiatrists, Royal College of Pathologists of Australasia, Royal Australian New Zealand College of Radiologists, Royal Australian New Zealand College of Obstetrics and Gynaecologists, Council of Medical Colleges, New Zealand College of Public Health Medicine, Australasian College for Emergency Medicine, Australian and New Zealand College of Anaesthetists, New Zealand Rural General Practice Network, Royal New Zealand College of General Practitioners.

current government's *Better Sooner More Convenient* health policy (Ryall, 2007) identified the need to strengthen clinical leadership, which purportedly includes nurses and allied health workers, as well as doctors. Peterson was not engaging with the health policy document, or choosing to misinterpret it, instead he took the opportunity to challenge the notion that NPs could be clinical leaders. He further stated:

The solutions to the challenges facing health care in New Zealand are complex but that they should fundamentally involve more doctors and more nurses working together in integrated, co-ordinated, GP-led health care teams through the patient-centred medical home. (Peterson, 2015, p. 3)

Peterson explicitly referred to several texts which reinforced the position of medical dominance and leadership, including the Canadian Medical Association (2008) and the American Academy of Family Physicians (2012). Links were made between NP work and a risk to public safety; and the necessity for NPs to work within collaborative and integrated health care teams, which were “general practitioner-led” (Peterson, 2015). These texts are explored further below.

## **Institutional work: Maintaining medical hegemony**

*Primary care* (though not necessarily primary *health* care) has been claimed by medicine as the ‘usual habitat’ of doctors (Gorman, 2009) since the late nineteenth century, following the colonisation of New Zealand (D. Williams, 2001). Through the early to mid-twentieth century western medicine consolidated its position of authority, both through education and by lobbying for legislation to protect its position, as the only profession able to diagnose and prescribe medications (Belgrave, 2012; Freidson, 1970; Group & Roberts, 2001). To reinforce western ideologies of medicine, traditional Māori healing (rongoā Māori<sup>51</sup>) was

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<sup>51</sup> The practice of rongoā Māori includes spiritual healing, the use of herbal remedies, massage and manipulation, and surgical interventions (Ahuriri-Driscoll et al., 2008).

legislated against through the 1907 Tohunga<sup>52</sup> Suppression Act and the 1908 Quackery Prevention Act. The distancing of health care from the rural indigenous population and positioning western medicine as superior, disenfranchised Māori (and indeed nursing) and remains today a cause of the significant health inequalities (Tuhiwai Smith, 2012). Further, the introduction of western medicine in New Zealand led to the development of hospital services with general practitioners as the gatekeepers of specialist medical services (Belgrave, 2012). Nursing work and education was under the direct control of doctors in hospitals, and the western medical profession asserted themselves as leaders of health care (Sargison, 2001).

The NZMA was formed in 1886 and continues to maintain strong links with the British, Australian, and other medical associations throughout the world (New Zealand Medical Association, n.d.). The special elite status that medical professional organisations created across the world resulted in politicians, bureaucrats, and the general public being convinced of medicine's superiority in all things concerning health (Freidson, 1970). Ivan Illich (1976) in his thesis *Medical Nemesis* wrote of diagnostic imperialism, and the medicalisation of life by medicine and pharmaceutical companies. By the 1930s, general practitioners, working through the NZMA, were a sufficiently powerful group to alter the course of the 1938 Social Security Act, preventing legislation which would have granted people free access to general practitioner services (Gauld, 2009).

However, the dominant discourse of biomedical science has come under threat in recent decades. The new public management of health systems, together with new models of service delivery, expanded roles of nurses and other health care professionals, and technological advancements, are perceived as eroding medicine's authoritative and diagnostic position in health (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010;

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<sup>52</sup> Tohunga are traditional healers who practice rongoā Māori. The Tohunga Suppression Act was repealed in 1962, however, in recent decades with the resurgence of Māori culture, there has been a growing recognition of the value in the practice of rongoā Māori for Māori health (Ahuriri-Driscoll, Boulton, Stewart, Potaka-Osborne, & Hudson, 2015; Best Practice Advocacy Centre (bpac), 2008)

Currie, Lockett, Finn, Martin, & Waring, 2012; Lipworth, Little, Markham, Gordon, & Kerridge, 2013). Bleakley (2013) identified that a crisis in public confidence, including through medical error and scandals, and the feminising of the medical workforce, has further *dislocated* medical dominance. The result is that professional medical organisations are needing to engage in institutional work to maintain their elite status (Currie et al., 2012).

Incorporating primary care NPs could be seen as a threat to medical dominance and the doctor-nurse power relationship (Bleakley, 2013; Price, Doucet, & Hall, 2014). Through the process of professional socialisation, doctors have learned of their historical position as responsible for all clinical decisions (Hall, 2005; Khalili, Hall, & Deluca, 2014). It is perhaps inconceivable to many of the medical profession that a NP could provide care comparable to a general practitioner and somehow fit within the existing system

Peterson's letter (2015) demonstrated the institutional work that the NZMA were doing to maintain their power and status in New Zealand. The production of the consultation text regarding the scope of practice of NPs (Nursing Council of New Zealand, 2014b) was read by the NZMA. The ensuing text-reader conversation resulted in action by the NZMA to develop a response to the Nursing Council. The institutional process of the consultation, described by the Nursing Council, indicated all submissions would be reviewed, and in turn a decision announced during 2016. However, Child was disappointed that the Nursing Council did not address issues raised in NZMA's submission (Lee, 2015). In November, 2015, the Nursing Council produced an *Analysis of Submissions*, and published all submissions where permission was granted to do this (Nursing Council of New Zealand, 2015a). The new scope of practice was announced in 2015, and became effective from 6<sup>th</sup> April, 2017 (see the full scope of practice on page 18, chapter one). The word 'complex' remained in the scope:

Nurse practitioners combine advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to provide patient-centred

healthcare services including the diagnosis and management of health consumers with common and complex health conditions. (Nursing Council of New Zealand, 2017c)

The work undertaken by the NZMA to develop a response to the Nursing Council consultation was informed by feedback from their Advisory Councils, members and the Board. The details of this engagement are unknown. However, what was apparent was the tracing of texts through the institutional layers. Additionally, and perhaps at the heart of their submission, was the intent to hold onto the ideological and historical discourses of medicine, exhibited in the texts quoted above. Despite the consultation on the new scope of practice being formally closed by the Nursing Council at the end of 2015, Child (quoted in Lee, 2016) has continued to argue against the decision. Indeed, this pattern of ongoing opposition from medical professional organisations is seen internationally, including from the American (2009), Australian (2005), and Canadian (2008) Medical Associations.

Peterson's letter (2015) to the Nursing Council, on behalf of the NZMA, referenced the Canadian Medical Association (CMA) (2008) policy statement on *Achieving patient-centred collaborative care*, and the American Academy of Family Physicians (AAFP) (2012) paper on *Primary care in the 21<sup>st</sup> century*, subtitled *Ensuring a quality, physician-led team for every patient*. Additionally, Peterson drew on the current New Zealand health policy principles of *Better, Sooner, More Convenient* (Ryall, 2007). This governmental text includes the principles of "working together for better care" and "integrated care" (Ryall, 2007, p. 3).

The AAFP has a membership of over 120,000 doctors working in family medicine in the US (American Academy of Family Physicians, n.d.). As with other professional medical organisations, the AAFP is strongly involved in political lobbying. The White Paper (American Academy of Family Physicians, 2012) presented the Academy's views on primary care through the model of the patient-centred medical home (PCMH), directly referred to by Peterson (2015). The vision of the PCMH was to provide transformational change in

primary care to improve health outcomes and ensure value for money through a team approach to health care (Agency for Healthcare Research & Quality & Patient-Centered Medical Home, n.d.; Rollow & Cucchiara, 2016). To date, evaluation has yielded inconsistent results, likely due to the range of organisational and service delivery models in operation, as well as methods of evaluation (Hoff, Weller, & Depuccio, 2012; Rollow & Cucchiara, 2016). The PCMH is a concept, which unless explicitly defined, potentially has no substantive content. Dorothy Smith would describe this as an *empty shell* concept (Smith & Turner, 2012).

However, for the NZMA the concept of PCMH not only aligned with current New Zealand health policy, but also maintained the doctor (or physician) as the key provider of primary care. In the second paragraph of the executive summary, the AAFP stated:

Within a medical home, each patient has an ongoing relationship with a personal physician trained to provide first contact, complex diagnosis, and continuous, comprehensive care. The personal physician leads a team of professionals at the practice level who are collectively responsible for the ongoing care of patients - many of whom are living with one or more chronic conditions. (American Academy of Family Physicians, 2012, p. i)

The team does include NPs. However, the point made is that the doctor leads the team, providing first contact for all patients. In response to the primary care physician shortage and the inevitability of NPs, the AAFP stated:

[S]ubstituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact...  
[N]urse practitioners do not have the substance of doctor training or the length of clinical experience to be doctors. (American Academy of Family Physicians, 2012, p. ii)

Nurse practitioners agree that medical training is different, and argue that working from a nursing paradigm committed to social justice, health equity, and empowerment is required

to address current global health issues (Meleis & Glickman, 2014). This is evident through the success of nurse-managed health centres operating in underserved areas where the focus is on holistic health care using a multi-disciplinary and community approach (Auerbach et al., 2013; Holt et al., 2014).

Globally the world is faced with increasing chronic disease, obesity, and ongoing (if not growing) health inequalities of poor, marginalised, indigenous, and displaced people (Stephens, Porter, Nettleton, & Willis, 2006; WHO, 2014). The biomedicalisation and pharmaceuticalisation of health and chronic illness, has focused medical research and practice on a *pill for every ill*, resulting in a health care system unable to understand and cope with the increasing complexity of health need (Busfield, 2010; Martin & Peterson, 2009; S. Williams, Martin, & Gabe, 2011). The WHO recognised that a new model of health care delivery is required to meet the current global health crisis (Commission on Social Determinants of Health, 2008).

The chronic care model aimed to transform care for people with long term conditions from acute and reactive to a proactive multi-systems approach (Bodenheimer, Wagner, & Grumbach, 2002), and the PCMH to a collaborative team approach (Agency for Healthcare Research & Quality & Patient-Centered Medical Home, n.d.). While evidence has demonstrated the link with practice organisation and health outcomes for individuals with specific disease types, the evidence is sparse in relation to people with, for example complex co-morbidities. (K. Coleman, Austin, Brach, & Wagner, 2009; Hoff et al., 2012). Further the western tenets of medicine remain treating the individual in isolation from family and community.

The health of indigenous people and nations globally highlights the necessity for a different model of care and approach to practice. Indigenous people have reduced access to basic western health care when needed, and that health care is often culturally inappropriate (Stephens et al., 2006). Durie (2004) stated that “indigenous knowledge cannot be verified

by scientific criteria nor can science be adequately assessed according to the tenets of indigenous knowledge” (p. 1138). Health and health outcomes are western constructs, and measuring indigenous health in this way is likely to be flawed due to culturally specific determinants, such as connectedness to land, sea, animals and plant life, language, and genealogy (M. King et al., 2009; Mooney, 2009). While there is a strong rhetoric for delivering culturally appropriate care, there are few studies that evaluate culturally specific health programmes (Clifford, McCalman, Bainbridge, & Tsey, 2015), and fewer that use indigenous research approaches (Tuhiwai Smith, 2012).

Returning to the white paper, the AAFP draws attention to the limitations of the work of NPs:

The training and certification NPs receive is appropriate for dealing with patients who need basic preventive care or treatment of straightforward acute illnesses and previously diagnosed, uncomplicated chronic conditions. But patients with complex problems, multiple diagnoses, or difficult management challenges require the expertise of primary care physicians working with a team of health care professionals. (American Academy of Family Physicians, 2012, p. 9)

The assumption made is that all patients are in receipt of primary health care, and have accessible to them the ‘expertise’ of general practitioners. Yet Peterson (2015) and Child (quoted in Lee, 2015) accept this stance without question or critique. They draw directly on the AAFP text to emphasise their views that NPs in New Zealand cannot diagnose and treat complex health issues, particularly when patients have co-morbidities. Missing again in Peterson’s and Child’s translation of this text is the evidence demonstrating NPs’ abilities to work with complex patients (P. A. Morgan et al., 2012). Further, they fail to acknowledge, as does the AAFP, both the lack of access to health care, particularly for rural, deprived, and indigenous populations, and that the current models of health care provision are not

reducing health inequalities (Jansen, Bacal, & Crengle, 2009; M. King et al., 2009; Woodward & Blakely, 2014).

An additional point of distinction between the US and New Zealand is that New Zealand has a nationwide NP educational, regulatory and legislative framework. In the US, on the other hand, legislation on the NP scope of practice and prescribing is governed by each state, rather than at a national level. This increases the variability of NP practice in the US, whereas in New Zealand, all NPs are assessed using the same competency assessment requirements and practice under a single scope of practice.

In Canada, the professional medical associations were following in a similar manner to the US. The Canadian Medical Association (CMA) policy statement (2008) supported greater collaboration between health providers to achieve quality, patient-centred care. Two of the “critical success factors” (p. 1) for collaborative care were that all service care models must support the patient-physician relationship, and the physician should be the clinical leader:

The physician, by virtue of training, knowledge, background and patient relationship, is best positioned to assume the role of clinical leader in collaborative care teams. There may be some situations in which the physician may delegate clinical leadership to another health care professional. Other health care professionals may be best suited to act as team coordinator. (Canadian Medical Association, 2008, p. 3)

The CMA policy statement correctly acknowledged the importance of collaborative care. Teamwork and interprofessional care are linked in health policy to improving patient care, safety, and outcomes (Manser, 2009; Xyrichis & Lowton, 2008). Rationale for collaborative care has originated from organisational research on developing team effectiveness (Lemieux-Charles & McGuire, 2006), from communication and teamwork failures resulting in patient adverse events (Leonard, Graham, & Bonacum, 2004; Mujumdar & Santos, 2014), and from the growth in long term conditions requiring improved collaboration between

health professionals (Körner et al., 2016). However, while there is mounting evidence demonstrating the effectiveness of collaborative or interprofessional teamworking, the lack of clarity over definition, organisational models, and measurement is problematic (Lemieux-Charles & McGuire, 2006; Leonard & Frankel, 2011; Xyrichis & Lowton, 2008). The notion of teamworking can too easily become rhetoric or an illusion (M. A. West & Lyubovnikova, 2013).

The above statement from the CMA is paternalistic. The doctor “may delegate” leadership, though if that happened, the implication is that the lesser position of “team coordinator” would be appropriate. Further, by using the term “by virtue of”, tells the reader that leadership is the physician’s legitimate position of authority, gained by moral excellence, righteousness, and goodness (Dictionary.com, 2016). Interestingly, there is no evidence to support the claim that doctors should be the clinical leaders of collaborative teams. Indeed, medical hierarchies, gender, professional socialisation and boundaries, are all inhibitors of effective teamwork (Bell, Michalec, & Arenson, 2014; Liberati, Gorli, & Scaratti, 2016; Price et al., 2014). The key for a collaborative team to develop authentic and effective teamwork is interdependence, shared objectives, and reflexivity (M. A. West & Lyubovnikova, 2013).

Finally, and in order to make their position on collaborative care explicit for governments and decision-makers, the CMA stated:

The effective functioning of a collaborative care team depends on the contribution of a physician. Governments must enhance access to medical care by increasing the number of physicians and providers, and not by encouraging or empowering physician substitution. (Canadian Medical Association, 2008, p. 5)

A physician substitute would refer to either NP or physician assistant. It seems evident that the CMA were endeavouring to affirm their historically held position of dominance within health. However, despite accepting that collaborative care is here to stay, the CMA were

strongly resisting relinquishing their medical dominance, a necessity if medicine is to be relocated as a collaborator within interprofessional activities (Bleakley, 2013). Again, there is a lack of consideration and concern for communities who have historically poor access to health care.

The NZMA (Peterson, 2015) fully engaged with both the AAFP and the CMA texts (American Academy of Family Physicians, 2012; Canadian Medical Association, 2008), activating those texts and reproducing and adapting them for the New Zealand environment within the context of NPs. The sequence of text-work-text is evident from the institutional ruling relations through to the local level. The NZMA text is received, and in turn activated, by those resistance bloggers who continue to feed the misinformation of public safety, adding stories that are without rationale. In doing so, the institutional ruling relations of medical dominance and importance are perpetuated, explicating the resistance NPs experienced by some general practitioners in their local settings.

Interestingly, when the Nursing Council publicly appeared to fail to engage with the NZMA text on the scope of the NP (Peterson, 2015), this caused “disappointment” for the NZMA (Lee, 2015). By not responding, the Nursing Council are seemingly not engaging with, nor activating, the NZMA text. They dealt with all 63 submissions in the same way, not privileging any one submission over another (Nursing Council of New Zealand, 2015a). By working in this way, the Nursing Council are activating texts and discourses that promote the profession of nursing.

## **The story about physician assistants: A cautionary tale**

Between 2009 and 2015, the physician assistant debate came to the fore in New Zealand. The topic engaged doctors and nurses, junior and senior, in and out of hospital, and NPs, alike. Misconceptions and misunderstandings spread including that physician assistants

(PAs) would increase the workload for senior doctors, reduce opportunities for junior doctors; that experienced nurses would be trained to be PAs, while NPs would just be PAs. After two pilots, that claimed positive results for PAs, all went quiet and the physician assistant role was put “on the shelf” (New Zealand Doctor, 2015).

I am retaining this story in the thesis for two reasons. Firstly, given the expansion of the physician assistant workforce internationally (Halter et al., 2013; Hooker, Cawley, & Everett, 2011), it is likely that at some point in the near future further steps will be taken to reintroduce PAs to New Zealand. Secondly, from an institutional ethnographic point of view, analysis revealed how power given to an individual resulted in newly created texts and ensuing work for various other organisations. Through the process, NPs were marginalised and work (and funding) that could have been undertaken supporting the NP workforce was instead diverted to the physician assistant workforce.

The tension regarding PAs was raised by primary informants in this research. The medical workforce is globally reducing, and PAs are now working in most areas of medical care in the US, and increasingly so in Canada and the United Kingdom. Physician assistants have been found to provide equivalent care when compared to physicians (and also NPs) using a biomedical model, and consequently are a cost effective workforce solution (Budzi et al., 2010; Drennan et al., 2015; P. A. Morgan et al., 2012). As with NPs, the first PAs in the US tended to work in rural and underserved areas. In 2011, 34% of PAs in the US worked in primary care (Hooker et al., 2011).

While assistants to doctors have existed for several centuries, the contemporary PA arose during the mid-twentieth century from the work of military medics (Cawley, Cawthon, & Hooker, 2012). Military medics complete a training in emergency care skills, diagnosis and treatment of disease, as well as knowledge to maintain health and hygiene (New Zealand Defence Force, 2013). They work directly under the supervision of doctors, though are often geographically separated. The US medical workforce shortage from the 1950s led to use of

retired medics from the military services in PA positions, including from World War II and the Vietnam war (Cawley et al., 2012). While some PAs still commence their career in military services, by far the majority are directly trained as PAs.

The PA role was defined for New Zealand:

[T]o supplement the work of doctors, extend their medical practices, and substitute for them in an expanding number of clinical tasks. The key attribute of the PA role is delegated practice under the supervision of a doctor; however, this does not preclude some degree of autonomous decision making. (Siggins Miller, 2012, p. 2)

Physician assistants are not a regulated workforce in New Zealand, Canada nor the United Kingdom, and are bound by varying licensing processes across the US. In contrast, NPs are regulated under the Health Practitioners Competence Assurance (HPCA) Act (2003), and are fully autonomous, authorised prescribers. They do not require supervision by a doctor, as do PAs.

The PA role was first advocated for in New Zealand as a way of solving the health workforce crisis in a report recommending the reconfiguration of the Clinical Training Agency<sup>53</sup> (Gorman, Horsburgh, & Abbott, 2009). Before specifically exploring the PAs' workforce progress, it was of interest to track how one individual moved into a position of power. The authors of the report were academics - Des Gorman and Margaret Horsburgh from the University of Auckland in medicine and nursing, respectively, and Max Abbott from AUT, in health and environmental sciences. The report proposed a two phase conversion of the Clinical Training Agency to ultimately evolve into a singular health workforce agency responsible for both planning and funding.

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<sup>53</sup> The Clinical Training Agency was a small unit of the Ministry of Health responsible for the distribution of funding for the training of qualified health professionals, including medicine and nursing.

The report (Gorman et al., 2009) was published by the Ministry of Health on 1<sup>st</sup> August, 2009. Five days later on 6<sup>th</sup> August Tony Ryall, the Minister of Health, announced that a new Clinical Training Agency Board was being established, to be led by Gorman (Ryall, 2009). The Board would work with the Minister of Health to drive the rationalisation of workforce planning, education, training, development and purchasing within the health and disability services sector (Health Workforce New Zealand, 2014). Max Abbott, later that same year, was also appointed to the Board. Additionally, Gorman was appointed as a board member to the newly formed National Health Board in December 2009.

The name of the CTA Board was changed to Health Workforce New Zealand (HWNZ) in 2010, and operated as a business unit within the National Health Board. The release of the latest New Zealand Health Strategy (Ministry of Health, 2016c), signalled the disestablishment of the National Health Board, with HWNZ remaining as a business unit in the Ministry of Health. Gorman continues as the executive chair of HWNZ. Throughout, he has remained in his position as Professor of Medicine at the University of Auckland.

The initial report on the CTA reconfiguration (Gorman et al., 2009) drew attention to the reduced primary care workforce of general practitioners and nurses. However, while the report noted that there were only fifteen NPs in primary health care at the time, the only recommendation was to undertake small-scale field trials of NPs working in chronic care, in a disease specific model, such as diabetes or chronic obstructive pulmonary disease. The potential of the NP workforce was not acknowledged in the report, despite the regulatory, legislative, and educational framework already in place. Instead, the report proposed the introduction of PAs as an example of developing a new workforce as a solution to the shortage of senior doctors in the hospital, and to general practitioners in the community.

Earlier in this chapter, Gorman featured strongly as a significant figure, who challenged the development and value of NPs as autonomous advanced practitioners who could provide primary health care services to the population (Gorman, 2009). Given his reticence to

support NPs, it is interesting how he introduced the PA to New Zealand as the solution, and through HWNZ, funded pilots to demonstrate their potential value. One commentator noted that perhaps Gorman's interest in PAs came from his time working in the Australian Navy and Royal New Zealand Navy (Fountain, 2010) where military medics work under the supervision of a doctor.

Gorman had every expectation that the PA role would be adopted in New Zealand. The report stated:

A tri-phasic approach is recommended.... The first phase would be to recruit already trained PAs from the US or UK to both prove the concept and to act as trainers. The second phase would be to send New Zealand students to one of the new PA programs in Australia for training – this would enable a supply of PAs during the period when the third phase, New Zealand based programs, were undergoing the process of development and approval. (Gorman et al., 2009, p. 35)

Later that year The Medical Council of New Zealand prepared a paper on the *Regulation and Training of Physician Assistants* (Medical Council of New Zealand, 2009). In this paper the Medical Council drew heavily on the use of medics (or PAs) in the New Zealand Defence Force, reviewing PAs in the US, Canada, and the United Kingdom. Ron Paterson, the Health and Disability Commissioner (Paterson, 2009), was asked to respond to the paper. While he suggested the PA role worth exploring in New Zealand, he did identify the potential for role confusion with NPs and stated:

[I]t may be more advantageous to develop skilled nurses who can practise independently and complement the services provided by GPs, rather than training PAs to assist doctors.

Despite challenges from nurses and doctors alike (Fountain, 2010; Graham-Smith, 2012; Powell, 2010) the pilots to introduce PAs to New Zealand went ahead.

Two pilots were devised to demonstrate the value of the PA in New Zealand. The first demonstration site, at Counties Manukau DHB in the hospital setting, introduced PAs for twelve months commencing in 2010 (Siggins Miller, 2012). The second pilot costing \$1.2m had four demonstration sites including one rural emergency department, and three primary care settings, two of which were rural (Appleton-Dyer et al., 2015). The evaluation of Phase I (the in-hospital setting) (Siggins Miller, 2012) identified that PAs could be “confidently introduced in a range of hospital settings” (p vi), with the success due to the medical model. The Phase II evaluation (rural and community settings) (Appleton-Dyer et al., 2015) found that the PAs improved the throughput of patients, maintaining workflow.

The focus on the throughput of patients was raised by one of the NPs in my research. She identified that the onus on the PA role was to improve the efficiency at which patients went in and out of the practice. This contrasted with her work as a NP where she focused on the longer term management of people’s health conditions, including chronic illness, and the effect of social issues in a highly deprived population. The NP stated:

When it comes to a NP versus a PA, there really is no versus, we really are quite different professions. (Informant 8, Group 2016)

Evident in the evaluation reports, was that PAs worked well in the clinical settings using a narrow medical model of assessment, diagnosis and treatment. While such a model can attend to acute presentations, including undertaking some clinical tasks, the model, being steeped within medicine, is not able to address the health needs of deprived, indigenous and rural populations (Commission on Social Determinants of Health, 2008). Further, the Phase II evaluation report (Appleton-Dyer et al., 2015) stated:

PAs have the potential to negatively impact on development of nursing. Key concerns raised were the growth of the PA role at the expense of the development of the NP role, and undermining the holistic value of the nursing role. (p. 11)

Both doctors and PAs are trained to work within the biomedical model, and this was given as a reason for, perhaps, the easier acceptance of the PA role into general practice. The NP stated:

As a professional group they [the GPs] aligned themselves more to the PAs. I think that was something that they had some familiarity with and so was more comforting for them. The other thing was the PAs always have to work under a medical professional, so that was another comfort [for the GPs].  
(Informant 8, Group 2016)

Doctors have held the responsibility and accountability for patient care throughout the era of modern medicine (Group & Roberts, 2001). As a consequence, general practitioners are not yet experienced in allowing other practitioners such levels of autonomy. However, as described earlier, when general practitioners are exposed to NPs, they value their work and collegiality highly.

Overall, while the evaluation reports signalled a success for the pilots, critique resulted with the PA project being placed on the back-burner (Cassie, 2015). On 5<sup>th</sup> August 2015, Ruth Anderson, HWNZ group manager, announced that no more money would be injected into a PA role (New Zealand Doctor, 2015). However, she did also state that the Ministry of Health would consider any applications for the regulation of the PA role, leaving the door open for the future.

Textual analysis of the intended introduction of the PA workforce to New Zealand revealed how a single individual was given the power to drive forward an agenda that was seemingly highly contentious. From his position as Executive Chair of HWNZ (a powerful organisation that he recommended establishing), Gorman created new and rewritten authoritative texts on the PA. But in doing this, he subordinated NPs. By proposing the PA workforce, investing money to demonstrate the value of the workforce, and engaging with a range of other organisations and health professionals, Gorman has firmly stated the position in favour of

the PA. Through this process, Gorman failed to engage with the discourses and texts promoting the NP workforce, both from New Zealand and internationally. Further, he failed to acknowledge the regulatory, educational, and legislative framework already in existence for NPs, preferring to set about creating a whole new framework for PAs.

## Summary

Through chapter six I have explored the ruling relations that are continuing to challenge the establishment of NP services in the general practice sector of health care in NZ. From the standpoint of the NPs and NP candidates, I explored the texts and discourses that were coordinating their experiences of being employed as a NP in general practitioner owned general practices. Quite deliberately in this chapter, I have focused on those ruling relations which continue to impede the growth of the NP workforce in rural primary health care. The NPs interviewed had all found employment in the general practice sector, however, their journeys were not straightforward, and they faced frustrations which they explained as money, business and profit, and encroaching on territory. They had to work to enter the contested space of general practice.

I have explored some of those texts and discourses that powerfully organised the NPs experiences to be employed in general practice. The model of general practitioner ownership in NZ has been strongly criticised as limiting the development of advanced nursing practice (Finlayson et al., 2012; Gauld, 2009; Wilkinson, 2007). I began by tracing those historical texts that have led to ongoing perseverance of the general practice ownership model. Of particular note has been the work that general practitioners have done (often through the NZMA) over the past one and half centuries to maintain their position as private businesses. Examples have included: rejecting the opportunity to provide free primary health care services under the Social Security Act 1938; rejecting subsidies and capitation for reduced fees (1980s and 1990s); and in recent decades despite significant

capitation income, continuing to persist with general practitioner-led care; and maintaining relatively high user-payments<sup>54</sup>.

Despite the evidence confirming the competence of NPs in primary health care, together with the policy drivers to reduce health inequalities and optimise the primary health care workforce, the ruling relations of general practitioner-led primary care have been maintained. The NPs and NP candidates described ongoing tensions that were perhaps surprising, given the apparent relevance and need for their role. By tracing texts published in the magazine *New Zealand Doctor*, through to those produced by the NZMA, I have shown the continued work to maintain medical hegemony in the primary care sector. The texts were traced up and through to international medical associations, including from the US, Canada, and Australia (American Academy of Family Physicians, 2012; Australian Medical Association, 2005; Canadian Medical Association, 2008). Further, the cautionary tale of the attempt to introduce the PA workforce to rural primary health care highlighted the ongoing determination by some to maintain medical dominance and leadership, and in turn subordinate and devalue the NP workforce.

General practitioners remain a powerful force in the primary health care sector in New Zealand at the local and national levels. At the local level, general practitioners as owners of practices are autonomous in deciding models of care and employment within their practice, and at a national level hold powerful positions, where they maintain medical hegemony. Despite the advent of funding to fully support the employment of advanced nurses and NPs, ultimately the decision lies with the individual general practitioners and practice. While there are a growing number of such practices who have successfully incorporated NP services into their model, these still remain in the minority. At the national level, the NZMA

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<sup>54</sup> Free visit to local general practices for under 13s were introduced from July 2015. 96% of general practices opted in for the zero-fees under 13s scheme. <http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/zero-fees-under-13s>

continues to work within its historical texts to maintain power over the primary care sector.  
The final findings chapter explores the fragmented health system in New Zealand.

## Chapter Seven

### A Fragmented System: Whose Interests' are Being Served?

#### Introduction

The primary health care sector in New Zealand is complex and fragmented (Cumming, 2011). In chapter one I provided a map depicting the structure of the primary health care sector and the possibilities where NPs could be employed (see page 27). In my study, NPs were employed in private, trust owned, and DHB owned general practices, as well as PHOs and Māori health providers. Primary health organisations were established to deliver on the 2001 Primary Health Care Strategy that was framed within a broad definition of primary health care, and closely based upon the WHO's Alma Ata Declaration (A. King, 2001; WHO, 1978). The six key directions of the Strategy were:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality using good information. (A. King, 2001, p. 6)

The Strategy signalled a “move beyond general practitioner-driven, fee-for-service, individually focused care” (Finlayson et al., 2012, p. 121) towards a population health approach. The DHBs were required to enact the Strategy through their funding and planning responsibilities. The Strategy was seen as an authoritative text within which the current

primary health care NP workforce could develop. However, the Strategy lacked any details of implementation, with the consequence that 81 PHOs were established under various and diverse models of governance and purpose (J. Smith & Cumming, 2009).

In chapter five I explored the pathway from being a RN in rural practice to becoming a NP. Texts and discourses were identified that entered into the local setting, and enacted by the RNs on this journey, which both facilitated and impeded their work to become authorised as NPs. I ended the chapter exploring Liz's journey to become a NP in a highly deprived area with many rural and isolated Māori communities. The mapping of her journey showed both the complexity of the primary health care system and highlighted the rapidly changing textual environment in which she was working. While many texts were at play, the confusion regarding the constantly changing policy and structure between the DHB, PHOs, and in turn general practices, ultimately stifled her progress.

In the previous chapter I explored the contested space in primary health care between general practitioners and NPs, identifying the work of the medical profession to keep NPs out of the practice area. I began from the experiences of the NPs and NP candidates, and explored the texts that were continuing to powerfully organise the perpetuation of general practitioner-led primary care services. I ended the chapter exploring the attempt to introduce physician assistants into primary health care, in essence turning a blind eye to the NP project, and the potential to implement NPs on a wide scale to help solve the general practitioner workforce issue.

The structure of this final findings chapter is itself a little fragmented. The purpose of the chapter is to explore various tensions that were raised by the NPs in their efforts to deliver health services to their communities. As with chapter six, the focus is on the stage from authorisation as a NP to working and implementing NP services in practice.



## Accessing medical specialists: Medical hegemony and institutional processes

The NP scope of practice includes “ordering and interpreting diagnostic and laboratory tests, ... and admitting and discharging from hospital and other healthcare services/settings” (Nursing Council of New Zealand, 2017c). As with the NPs’ experiences of general practitioners, their experiences with medical specialists was variable, ranging from supportive and helpful, to refusing to accept referrals from NPs. Elaine stated:

Initially of course when I started referring - I’d been through the DHB. I’d been through funding and planning, the whole thing. I did everything, and radiology were a pain but we got through that. But the specialists, oh my God! The specialists - and they would accept my referrals privately but not publicly, you know? (Elaine)

Medical specialists run their own private businesses where the patient pays for their services, either individually or through insurance schemes. In this instance, the medical specialists engage in a direct contractual relationship with the patient. Within the public system, medical specialists are governed by DHB funding limitations and clinical parameters. These include, for example, the number of First Specialist Appointments (FSAs) in any given specialty, and referral care pathways, which explicitly determine both the eligibility of patients to receive a service, and the timing of the referral.

Access to radiology services has often been cited by NPs as being a problem. Alana described how radiology refused to accept referrals from NPs on the basis of NPs requiring further training. Despite having received training and authorisation to request radiology in a previous rural location, the radiology SMO insisted that she had to do the training.

Because this DHB has decided that I need to do some more training in order to do that. I need to do a course at the DHB – their own course... So I rang [the radiologist] and said “OK, apparently I need to do some training.” She

said well we won't be doing any at the moment. It won't be until next year" - this was in May. I said "OK, so there's nothing I can do?" "No, you can't order [radiology] until you've done this training." ... She said "I'm off to do some more training about how to train NPs and others". (Alana)

While the NP has found some ways to work around this, there have been times when this has posed a problem for the safety of the patient. For example, a radiology request for an ultrasound for a man with a differential diagnosis of deep vein thrombosis was rejected by the radiology department as it had been signed by the NP, and not a doctor. A letter was sent to the general practitioner stating that "If the patient still required this ultrasound, please reissue a referral". The patient had travelled to and from the X-ray department (over 25 km away from the practice) for no reason.

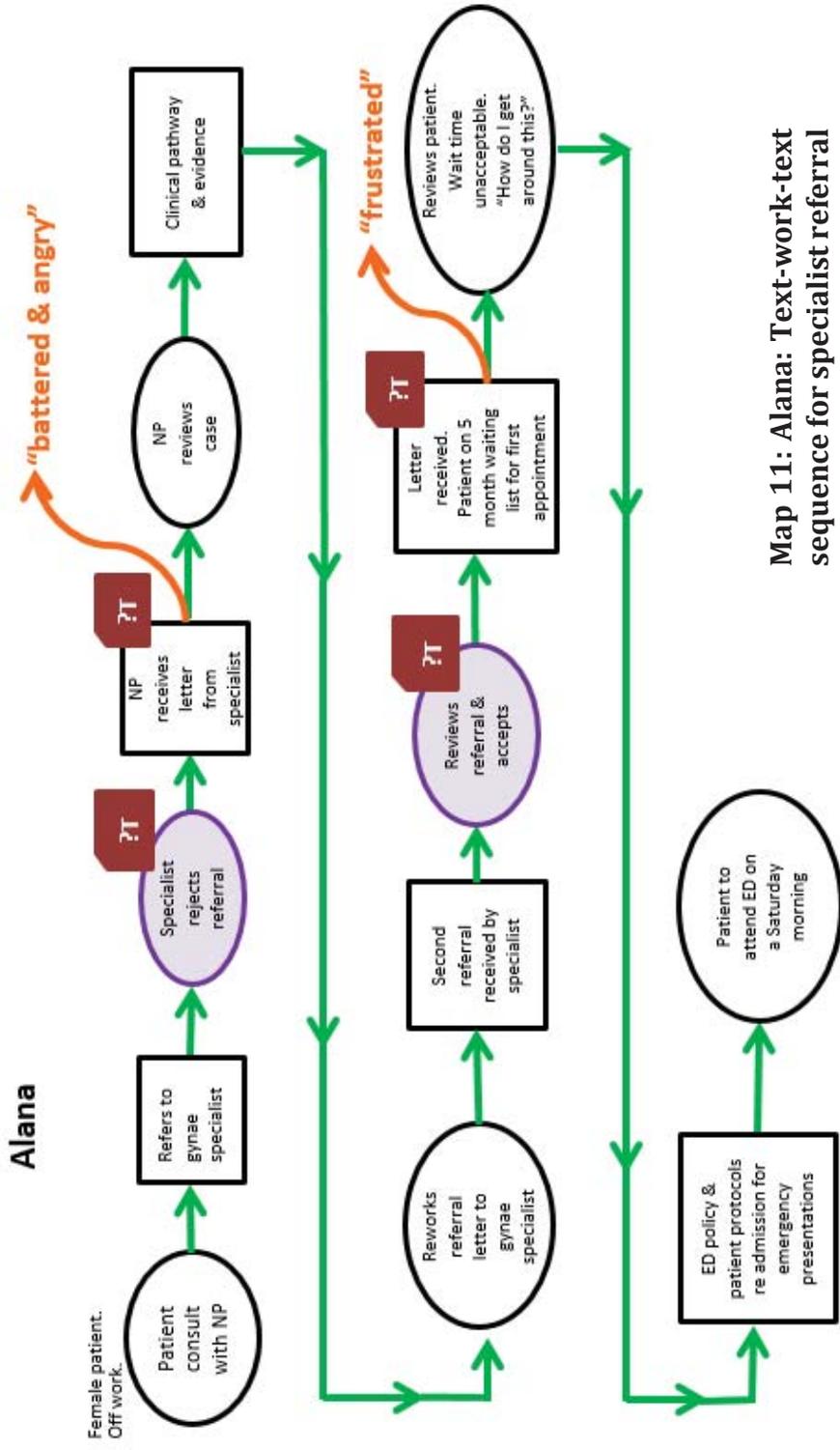
From a group interview with NPs in early 2016, difficulties were specifically identified in referring to radiology services within their DHB. Difficulties of NPs referring to radiology have been recorded previously in New Zealand literature (Unac, Marshall, & Crawford, 2010). The NPs explained how the DoN was continuing to work to solve the problem of referral, and had been for the previous eighteen months. Institutional processes, including training policies, referral requirements, and referral forms requiring NP registration numbers, along with some resistance from the radiologists themselves, were identified as particular texts impeding the process. In 2015, criteria published on community radiology were developed to "assist primary care practitioners to manage radiology patients effectively in the community by ensuring they get appropriate access to diagnostics" (Ministry of Health, 2015b, p. 2). The document explicitly included NPs.

Alana described her frustration at the hospital specialists' response to some of her referrals:

Some of the stuff I'm sending through that they're saying no to, they won't see, they say it needs to be referred by a doctor. That is concerning me,

because I've had a couple of patients who have needed to be seen. They have had serious things. For example, post-menopausal bleeding...

The map on the opposite page (p. 219) shows the text-work-text sequence that Alana was going through at the time of interview in order to get a patient seen by the specialist services. Alana described a 45-year-old woman, who was unable to work, as a “complete wreck”. She had a severe uterine prolapse with occasional urinary retention. In this map I have identified the points at which she responded to the texts as she read them. Her initial referral to the gynaecology specialist was rejected without adequate explanation. She described her embodied experience on reading the letter as “battered and angry”. Alana reviewed the case in accordance with the local care pathway and evidence for the presenting complaint. She reworked her referral letter to demonstrate that the patient met the criteria for referral to the service. In this second instance, the specialist accepts the referral, however, on this occasion places the patient on a five month waiting list for a first appointment. She described how “frustrated” she felt, and was unclear regarding the rationale for the length of wait. Alana then reviewed the local emergency department (ED) protocols for admission. Given her assessment and exploration of differential diagnoses, her clinical decision was that her patient warranted admission, further investigations and treatment. Ultimately, she advised the patient to attend the ED on a Saturday morning. Throughout the interview, Alana had referred to the doctor – nurse power relationship. However, she remained unable to understand how a specialist could reject her referral, compromising the patient’s health and safety.



Map 11: Alana: Text-work-text sequence for specialist referral

In contrast to this experience, Alana described how she worked extremely well and in partnership with a palliative care specialist. She described how this specialist had commended her on her referral letters as being accurate and informative. Elaine explained the level of scrutiny that NPs were under:

They scrutinise our documentation which is imbedded in the referral letters. They scrutinise the tests that we use and the actions that we take after those tests, and they then examine the patient and they confirm or deny our findings. (Elaine)

The complexity of the issues described by Alana and Elaine were evident in ensuing interviews with a planning and funding manager and a chief medical officer. When asked about the difficulty NPs were experiencing regarding referrals, the planning and funding manager explained:

There are some SMOs (senior medical officers) who have not been accepting referrals from the NPs and not replying back to the NPs, but instead replying back to the GPs. This may be a technical problem where the secretaries of the SMOs are unable to pull up the names of the NPs. So work has been done on this to change this to ensure the NPs' names are on the database – but it will be interesting to see whether this was an excuse, or whether behaviours do change as a consequence. (DHB Funding & Planning Manager)

The electronic referral systems had previously not allowed for NPs to enter their registration numbers into the DHB database, with the result that their details were not available for automatic replies. However, both Elaine and Alana identified that some specialists managed to find their details, whereas others did not. Both the funding and planning manager and the chief medical officer were aware of some of the specialists' resistance to accept referrals from NPs. In the quote above, the funding and planning manager identified that 'behaviours' of individuals have a part to play in the issue. An ethnographic study in the United Kingdom identified that NPs experienced acts of medical

resistance when referring to hospital services (McMurray, 2011). McMurray proposed that protecting medicine's occupational territory and fear of erosion of their diagnostic jurisdiction was central to the experience of resistance.

### **A senior medical officers' forum**

In 2014, a senior academic presented on the NP workforce to a forum of approximately 25 medical specialists. The divergence of opinion on NPs was evident. One senior doctor described how he had worked with NPs in the US:

I mean I've worked with NPs in long term care. The partnership worked very well. They made a lot of the routine visits. You could alternate care and they knew the scope of their practice. They would escalate more complicated problems to me. We worked as a team. It worked very well.

(Senior Medical Officer 1)

There was confusion regarding the distinction between clinical nurse specialists (that several called "specialist NPs", working in the hospital environment, and NPs working in primary health care. While they identified that the clinical nurse specialist<sup>55</sup> was an important role, they were reticent about the development of generalist NPs to work in primary care at the equivalent level of a general practitioner. One stated:

I need to disagree. I mean I think the specialist NPs [*meaning* clinical nurse specialists], the urologists you talked about, pain nurses, diabetes; I mean they're the ones that have such better knowledge than a house surgeon. They're invaluable because, you know, we go to them when we think, "Right, I don't know much about this. I need to get some information", and they have such a good specialist knowledge, whereas I think you'd lose that. I think a lot of the success of the guys you talked about are because they're specialists in their field, not because they're generalists. So then you'd lose a lot, like

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<sup>55</sup> A nurse specialist in NZ is a RN and usually works within a specific service, and often a disease specific service. Typically, they have some postgraduate education, but not necessarily a master's degree (though this is increasingly expected).

you'd try to persuade them to go away from being a specialist nurse to a more generalist. (Senior Medical Officer 2)

The medical generalist versus specialist debate perhaps reflects contemporary dialogue within the New Zealand health system (Atmore, 2015; Gorman, 2016). Over recent decades the proportion of medical specialists compared to generalists has increased, as have the number of medical sub-specialities (Ministry of Health, 2014c). Atmore argues that the ongoing development of sub specialisation has “allowed doctors to create areas of service which they can stake a legitimate claim on as their territory” (p. 51). Such a model delivers segmented and fragmented care which is not in the interests of people with multiple and complex health issues (Atmore, 2015). Clinical nurse specialists sit within the hierarchy of the medical specialist team, where medicine continues to retain its dominance (Battilana, 2011; Currie et al., 2012). On the other hand, a generalist NP would practice autonomously, though collaboratively, and potentially outside of medical control. It is the generalist NP who has been identified internationally and in New Zealand as a valuable, indeed necessary, provider of primary health care services, particularly in rural and underserved areas (Carrier & Yarwood, 2015; K. Francis et al., 2014; Institute of Medicine, 2011; Kippenbrock et al., 2015).

Incorporating primary care NPs is often seen as a threat to medical dominance and the doctor-nurse power relationship (Bleakley, 2013; Price et al., 2014). However, it could be that through the process of professional socialisation, doctors have learned of their assumed historical position as responsible for all clinical decisions (Hall, 2005; Khalili et al., 2014), and as such it is perhaps inconceivable to them that a NP could provide care comparable to a general practitioner and somehow fit within the existing system. An emergency department senior doctor raised:

So if the NPs you're talking about work in primary care, my question is about where they really fit into the hierarchy? (Senior Medical Officer 3)

To further the point that there was not a need for NPs, the emergency department senior doctor described how NPs regularly referred out of hours for patient problems that could be dealt with by a general practitioner. While this was challenged during the forum, it was afterwards confirmed (by the primary care NPs) that these referrals had come from RNs (not the NPs) who were providing an 'out of hours' service<sup>56</sup>. It is not known whether the doctor was misleading his peers, or whether there was a genuine lack of understanding of NP work.

The over-ordering of investigations and over-prescribing was taken up by another senior medical officer:

We already, in New Zealand, have a problem largely created by government via funding policies, of over prescribing of drugs and over asking of investigations. An investigation asked for by a registered medical practitioner is free to the consumer. That means there's absolutely no market to put a damper on it. The legislation<sup>57</sup> you mentioned, as I understand it, would widely increase the number of people who could order, with a blank cheque, investigations, but similarly prescribing. (Senior Medical Officer 5)

Another specialist challenged NPs' education and competence with a rhetorical question:

Is the NP adequately trained to diagnose problems, to have enough understanding of the differential diagnoses, to order appropriate tests - and my concern in child health is that too many tests get ordered, unnecessary bloods, unnecessary x-rays, without a focus on clinical skills that are required during, you know, during six years of training to be a doctor? And

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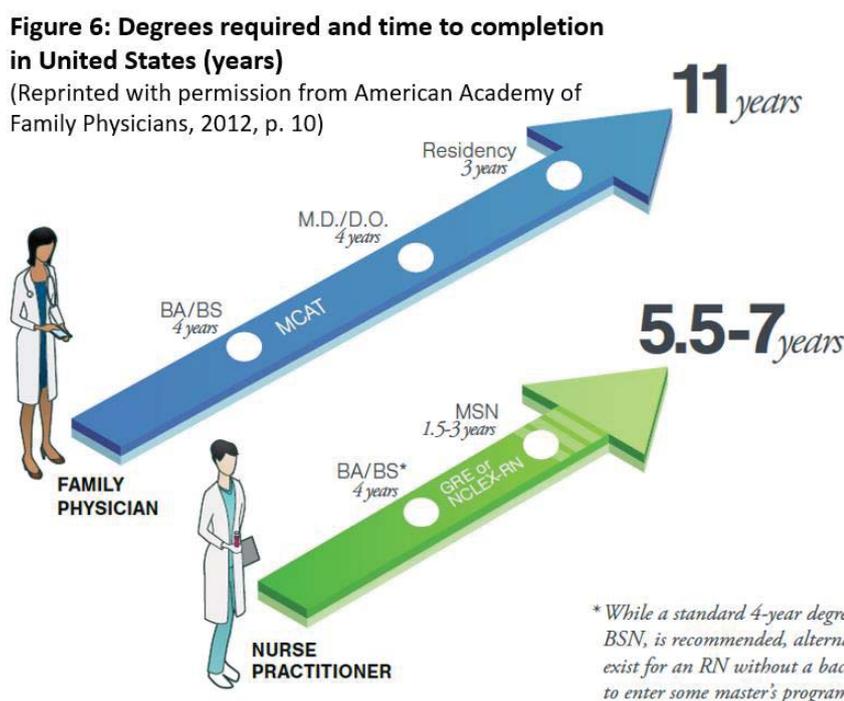
<sup>56</sup> Out of hours' services are primary health care services provided outside of the usual general practice hours for emergency care. Workforce and funding constraints in NZ have resulted in various out of hours' services being provided, included by general practitioners, NPs, locums, RNs and paramedics. While people in urban areas often have access to Accident & Medical (A&M) centres, or to publicly provided emergency departments (ED), in rural areas out of hours care often has poor coverage with long waits for emergency services.

<sup>57</sup> Several pieces of legislation had been referred to. However, in this statement, the legislation was likely to be the Medicines Amendment Act, 2013, where NPs would be authorised prescribers.

then to be honest an MB/ChB<sup>58</sup> is really only like having School Cert in medical terms. (Senior Medical Officer 4)

The statements regarding over-prescribing and over-use of diagnostic tests is unsubstantiated in the literature. The use of diagnostic tests by NPs in comparison to doctors has been found to be either similar (Dierick-van Daele et al., 2009; Pirret et al., 2015) or marginally higher (D. R. Hughes, Jiang, & Duszak, 2015), and prescribing practices comparable (Gielen et al., 2014).

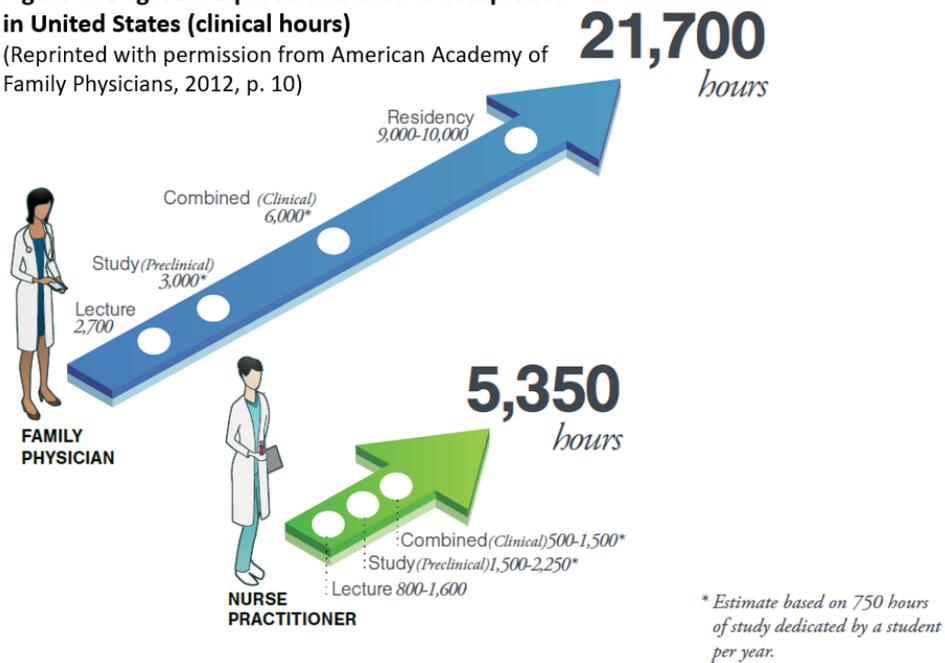
It is accurate that medical training and further vocational training is lengthy. In the AAFP white paper (American Academy of Family Physicians, 2012) a graphic was presented showing the difference between years of training between a family physician and a NP (shown below); and in the hours of clinical training required (shown opposite on page 225).



<sup>58</sup> The bachelor of medicine and bachelor of surgery is a six-year university programme. For doctors who wish to train as a general practitioner, they are expected to have two year postgraduate rotations in hospitals. Year one of the general practice registrar (GPEP Year 1) involves two 26 week rotations with attachments at an accredited teaching practice. For a further two years (GPEP Years 2/3) doctors work at a senior registrar level of at least four tenths in clinical practice. Toward the end of this period the GP trainee sits the Royal New Zealand College of General Practitioners primary membership examination.

**Figure 7: Degrees required and time to completion in United States (clinical hours)**

(Reprinted with permission from American Academy of Family Physicians, 2012, p. 10)



Such data, it would seem, should support the rationale for utilising NPs at the full scope of their practice. The training costs of NPs in comparison to general practitioners are much lower, and yet NPs provide at least equivalent care (Dierick-van Daele et al., 2010; Martínez-González et al., 2014; Swan et al., 2015). In New Zealand, a rough estimate of the costs of training a NP was \$120,000 versus \$550,000 for a general practitioner<sup>59</sup>. Funding for general practitioner training increased to \$22 million for funding 170 places for the three-year training period from December 2014 (Ryall, 2014). In 2015 health minister Jonathan Coleman announced \$846,000 to fund twenty NP trainees in 2016 for their final academic year of training (J. Coleman, 2015).

The dialogue in the senior medical officers' forum had progressed through from concern about NPs being generalists, to their competence to diagnose and treat, to their over-prescribing and over-use of investigations. Finally, the group returned to the age-old edict that the solution was to train more general practitioners and to make general practice much

<sup>59</sup> This data was calculated in 2015. The data was based upon educational fees from entry to a bachelors programme for either nursing or medicine, and through to completion of a master's in nursing, including supervision fees; or through the general practitioner three-year education programme.

more appealing to medical students and junior doctors. The shortage of rural general practitioners is a global issue, and the evidence base weak for schemes to recruit and retain doctors (Verma et al., 2016). Various rural funding initiatives implemented in the early 2000s in New Zealand had little impact on the overall general practitioner workforce issue, though individual practices reported significant benefits (Goodyear-Smith & Janes, 2007). Rather than spend a proportionally high amount of HWNZ funding on general practitioner training (Ministry of Health, 2014e), perhaps this money could be used to support the growth of the rural NP workforce, and in turn increase access to health services. The ongoing need for locum doctors illustrates that the general practitioner workforce model is not working.

### **Locum doctors: An expensive band-aid**

Locum doctors in New Zealand are considered essential to maintain health services both in public hospitals and in primary care (Gauld & Horsburgh, 2015). Additionally, in rural primary care, locums are a necessity to improve the retention rates of permanent doctors (J. L. Thompson, 2014). While some New Zealand trained doctors do undertake locums on a regular basis in rural areas, many are from overseas, including Canada, UK and the US (Medical Council of New Zealand, 2012).

The transitory nature of the locum doctor workforce in rural primary health care was described by one primary informant while working as a rural nurse specialist:

In the first few years I had sixteen different doctors in a two-year period. When I arrived there the permanent one was all set to leave. We had a previous doctor come back to fill in for a couple of gaps and then we had an American doctor arrive. I remember the first week he was there and he said to me one day, "Who's covering the [southern area]?" I said "You and me". It was "Oh dear! What do we do?" I said "We just hang tight. There are

ambulances in all those areas. If there's something they can't handle they will get the patient on the road. There are helicopters that can fly in and transfer the patient or fly you down ... we'll just wait and see" ... We survived.

(Leanne)

New Zealand has a particularly heavy reliance on the overseas trained medical workforce with over 50% of all doctors being trained overseas (OECD, 2015). Strong migration 'pull' factors, in terms of quality of life and work opportunities, result in New Zealand having the highest numbers of overseas trained doctors in any OECD country (Gauld & Horsburgh, 2015). Of general practitioners, 43.7% are overseas trained, as are up to 54% in rural areas (Medical Council of New Zealand, 2012). General practitioners remain on the long-term skill shortage list for immigration to New Zealand (Immigration New Zealand, 2016). While the global migration of the workforce has many positive elements, many overseas trained doctors leave New Zealand within one to two years (Association of Salaried Medical Specialists, 2014; Medical Council of New Zealand, 2012).

In order to assist the general practitioner workforce shortages in rural areas and improve retention, the Ministry of Health established a Government-funded contract to support the recruitment of locum doctors and locum NPs. This contract is operated by NZLocums who are a business unit of the New Zealand Rural General Practice Network. On the NZLocums website, they describe rural practices as being "located in the most beautiful places in New Zealand, with mountains, beaches, lakes or rivers at the doorstep." (NZ Locums, n.d.). The purpose of the contract is to provide short term locum doctors to cover leave for rural general practitioners, as well as recruiting longer term locums and potentially permanent positions.

The recruitment service provided by NZLocums includes sourcing candidates from New Zealand and overseas, and supporting potential candidates through the process of immigration and gaining temporary registration with the Medical Council. The Medical Council work proactively with NZLocums to recruit and register overseas doctors. The

locum support scheme entitles all rural general practitioners and NPs to access locum cover for two weeks per annum (per full-time equivalent). In 2016, there were 198 rural practices and approximately 400 rural general practitioners (Deputy Chief Executive, Linda Edwards<sup>60</sup>). Edwards estimated that at any one time over the previous five years, around 25% of rural practices would have a permanent vacancy. Further, there are certain areas that require locum support on a regular basis, such as where Leanne had worked with sixteen locums in a two-year period. NZLocums recruit locum doctors for a minimum of three months, though prefer six months. However, the length of their locum placement is often much shorter, affecting continuity of care.

Yet, the current extensive use of locum doctors to the health sector is costly. Locums working in general practice on a short-term contract would expect to be paid between \$111 and \$115 per hour (Medical Assurance Society, 2015). Further, rural locum doctors are likely to receive a higher rate of pay and potentially receive benefits, such as accommodation, car, or professional subscriptions (Medical Assurance Society, 2015). On the other hand, a permanent NP would likely be paid between \$55 and \$65 per hour. One practice manager described how she had built the business case for a NP largely on locum costs and quality of care (the model for this practice is described in the following section).

The frequent turnover of doctors posed problems regarding lack of knowledge of the health care system, resulting in extra work for the nurses, and a lack of continuity of care regarding management. Leanne stated:

They might change medications and they'd leave, so it was quite difficult getting patients stabilised. (Leanne)

Further, they might not have the current skill set to work in rural settings:

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<sup>60</sup> Linda Edwards was the Deputy Chief Executive of the New Zealand Rural General Practice Network, and former manager of NZLocums. and consented to participate in this study. The interview was conducted in February, 2016.

I said to [the GP], “Now you’re my backup person. If I can’t get a cannula in someone and I need help, I’ll call you.” He said “No good calling me. I haven’t cannulated in fifteen years.” So you were it - which is really quite frightening. (Leanne)

Whereas advanced rural nurses undertake a PRIME (primary response in medical emergencies) course, often locum doctors do not have this level of emergency training outside of a hospital environment. In addition to skill set, examples were given of focus for the locum doctor being on a working holiday. For example:

We had a [locum] GP that you couldn’t find. You’d ring him up he wouldn’t answer his cell phone ... He wouldn’t answer if you paged him; we’d ring the clinics... we’d get the ambulance to activate his car horn ... but he wouldn’t [respond]. So in the end I might ring a [nursing colleague] and say “I’ve got this patient who needs this medication. What do you think?” [Leanne]

For some, being a locum doctor is a lifestyle choice and a way of seeing the country with or without their families. A locum general practitioner commented in New Zealand Doctor about how difficult it was for practices reliant on locums and part-time doctors (McMillan, 2014). She admitted that it took a few days for her to learn how the practice runs and to get to know staff and the community. Because of this, she decided to spend at least four weeks in each practice in between travelling with her family. In no way does a system supporting such a working arrangement uphold the key directions of the Primary Health Care Strategy (A. King, 2001).

The short time period that locum doctors often spent in rural practice was a source of dissonance for the NPs. They were fully aware that they could provide an improved service for patients:

There’s a professional responsibility upon all of us, and I think we’re all conscious about that. It’s not only that but it’s obviously for the benefits of our community, because most of us live in these communities. We obviously

want to see NPs grow. We want to see wellbeing, and I know in our communities it's still hard to keep permanent GPs. So we either - I know we turn over the locums still. (Informant 3: 2014)

The NP was describing the necessity of knowing the community in which you were living, as well as having a vested interest in their health and wellbeing. Another NP stated:

For me I focus on the whole reason why I became this nurse practitioner, went into this role, I go back to that. I feel I really am part of my community. I want something there for my mum and my brother. That's what you want. It doesn't matter what the knocks are. That's exactly why I was created and why I wanted to be in this role, and I go back to that. And nobody - and I mean nobody - is going to take that away from me, my vision. And if somebody - if they put the barriers in the way, that's life. But at the end of the day this is my vision. (Informant 4, Group 2014)

Sue: And your vision was?

That I was going to be a NP, and I was going to make a difference for my community. End of story. (Informant 4, Group 2014)

There is a considerable discrepancy between the locum general practitioner who took a few days to *know the community*, and the NPs who worked for the benefit of their communities, understanding rural health need, and the value of continuity of care. The difference between the biomedical model and nursing model of health and social justice are perhaps at the heart of these differences.

Continuity of care has been subject to considerable research, particularly in primary care. Continuity of care includes both interpersonal continuity with the same clinician, and continuity with the same practice. A literature review revealed that continuity is linked with lower hospitalisation rates, fewer complications for patients with long term conditions, reduced emergency department visits, reduced health care costs, improved prevention and

improved concordance of evidence-based guidelines (O'Malley, Rich, Maccarone, DesRoches, & Reid, 2015).

In Sweden, a qualitative study on fourteen people with chronic illnesses and sixteen health care professionals across three different primary care centres was conducted comparing experiences of having short-term locums and permanent doctors (von Bültzingslöwen, Eliasson, Sarvimäki, Mattsson, & Hjortdahl, 2006). The researchers identified that the experience of short-term locum doctors conveyed feelings of insecurity and anxiety, and patients' frustration at having to repeatedly tell their stories. Additionally, staff and patients noted a lack of coordination and patient progress, and repeated phone calls and re-visits from patients who had seen locum doctors were required.

Further, patients who do not have continuity of care are also more likely to 'fall through the gap' arising from failures in communication and coordination of care (Tarrant, Windridge, Baker, Freeman, & Boulton, 2015). The concept of candidacy was used in research to explore how more vulnerable populations identify their eligibility for health services, and negotiate their way through the health systems (Dixon-Woods et al., 2006). Tarrant et al. concluded that patients who had complex conditions, and were in some way disadvantaged and vulnerable, and who did not have an ongoing relationship with a trusted health professional, were likely to be particularly vulnerable to unresolved breakdowns in care. Such evidence would support the employment of permanent NPs rather than the ongoing short-term contracting of locum doctors.

Interestingly, there is limited evidence in the literature on the quality of work provided by locum doctors. Perhaps this is due to the heavy reliance on locum doctors within health services, and the risk of needing to find alternatives should the findings be adverse. Nolan, Kandel, and Nakayama (2015) surveyed the American Pediatric Surgical Association members and identified that 64% believed that locum cover did not provide the same level of care as a full-time community-based surgeon. Research comparing locum-led primary

care and regular general practitioner care found that both an over-referral and under-referral occurred to local specialists (Gjessing & Faresjö, 2009), though this evidence was far from conclusive. In Australia, overseas trained doctors were found to be more likely to attract complaints to medical boards and be subject to disciplinary procedures than Australian trained doctors, but the risks differed markedly depending on their country of training (Elkin, Spittal, & Studdert, 2012).

Elsewhere, the perhaps over-use of locum doctors had created opportunities for NPs in this research. One participant described how it was the overseas doctors who particularly supported the development of her as a NP.

We had the support [of the practice] and we had the likes of the overseas doctors coming over that were already used to NPs so it wasn't such a foreign idea, ... whereas New Zealand doctors were still having issues with it. At the moment we've got quite a number of overseas doctors, and it isn't unusual for them to have worked with a NP [in general practice]. So that's why I think the expectation was there that it was okay for me to be a NP.  
(Jane)

In another area, instead of using locum doctor coverage for after-hours work, a NP was appointed:

That was their [the DHBs] idea, that we put a NP in instead of another doctor. (Elaine)

A further small success was announced in September 2015, when NZLocums recruited a NP into a permanent position in a rural general practice (Scoop Media, 2015). Overall, however, it seems that the ongoing utilisation of locum doctors is not serving the community in terms of quality and continuity of care, and nor is it serving the country in terms of costs. Further, locum doctors are perhaps further constrained to work within the biomedical model of care, due to their lack of knowledge of the local health and social services, and the community's

health needs and resources. On all levels, continuing with a model of utilising locum doctors is little more than a very expensive band-aid.

### **A model of practice: Putting the community first**

One NP, who had been working in a rural practice in a very deprived area of New Zealand, described a relatively easy transition from practice nurse to NP. The business model, developed by the general practitioner owners of the general practice, with the practice manager, supported the career pathway of RNs and NPs in the practice, and enabled a strong multidisciplinary environment. Of particular interest to this IE, was how the general practitioner owners, the practice manager, and the NP, all engaged with texts that facilitated the development of this practice model. Indeed, the lead general practitioner paid no attention to other circulating negative texts regarding NPs.

The lead general practitioner had experienced working with NPs in primary health care overseas, and was keen to establish this model in the New Zealand rural practice. He stated:

I came from a very busy deprived area in the UK, and NPs were the way ahead for us there. I'd seen them work and I'd seen them work well with us. I'd always thought of them as being an asset. And, you know, some doctors I think feel threatened by the NPs, seeing it as taking away some of our work, though my viewpoint is that we've already got too much work, that we can't deal with it all ourselves, and somebody to help us is a good thing. (GP)

The NP, Jane, described how a career pathway framework for the RNs working in the practice had evolved over a number of years. Jane was the first RN to become a NP, and a further two RNs were currently progressing on their postgraduate pathway, working towards their authorisation as NPs. Jane described the organisational support:

I think we [the practice] had an expectation of trying to get all our nurses to work at that top of their scope as well, so that's not just with NPs, it's through the whole organisation that we're expecting our nurses to be growing and becoming more independent. (Jane)

Jane found that she was regularly asked by the general practitioners, nursing colleagues and practice manager "when are you going to be qualified?" This discourse strongly signalled to Jane that she would be employed as a NP, with her team colleagues expecting her to be working as a NP in the practice. She found this support, combined with the support of the PHO (described in chapter five), drove her forwards to complete her registration as a NP.

As a newly registered NP, the practice immediately employed her as a NP. Despite this, there was a period of transition where Jane had to work to develop new relationships with all staff in the practice to establish her changed position. Ways of working with general practitioners, RNs, and administrative staff needed to change, as did systems, such as scheduling appointments, acute appointments, and the ongoing work to develop her own caseload. Any individual commencing a new job, or changing jobs within an organisation, would expect a period of adjustment to develop acceptance by others (T. N. Bauer, Bodner, Erdogan, Truxillo, & Tucker, 2007). Jane described this as an "iterative" process where good communication with all staff was central, made possible through weekly catch-ups with the lead general practitioner and practice manager, and regular team meetings. The organisational climate of primary health care settings has been identified as critical in supporting the development of the NP workforce (Poghosyan, Nannini, & Clarke, 2013; Poghosyan, Nannini, Stone, et al., 2013).

When asking about what work the practice had to do to support Jane transitioning to a NP, the general practitioner responded:

I mean, you don't finish [qualifying] as a NP one day and you know everything the next day – that doesn't happen, so there is a build-up to it,

and it's been, you know, she's gone through that, and she's quite capable of sorting out things herself. (GP)

What have you had to do as GPs to make that happen, or help her to do that? (Sue)

One of the things we've done that was a big upheaval for the practice, was we stopped paying ourselves on the number of patients we were seeing. So rather than seeing patients with coughs and colds and sore throats – basically easy patients, and you're reviewing them in a week and making easy work – we stopped doing that, so we just get paid for the time we're here, and then you use the time as effectively as possible, and some of that is spending time with Jane and working out care plans, so that's been important. (GP)

The general practitioner went on to describe that the transition to a new business model was “quite traumatic”. He stated:

We're not high-earning GPs, and we're – I think we're pretty patient-focussed, being over here in [this rural area], and we could see it was making sense. I mean, some doctors took a hit in their salary, but it just seemed to be the best way forward. This practice has always been focussed on providing good health care really for the population. (GP)

It is evident in this statement that the purpose of the practice was to provide health care services to the community it served. I would suggest that by far the majority of general practitioners in New Zealand hold the same philosophy, that the purpose of their work is to deliver good health care to their patients. However, what is different in this practice was that in order to provide good health care, there was a recognition that the existing model of private general practice ownership and business was not working. Instead, a salaried model was introduced. Rather than general practitioners focusing on the throughput of patients, there could be instead a focus on quality of care and multi-disciplinary teamworking.

The practice had begun planning Jane's employment as a NP eighteen months before she registered. The practice manager described how the practice had changed its model for paying the general practitioners and how she had undertaken cost calculations to demonstrate the advantage of employing a NP, including allowance for the cost of investment in supporting her training. Regarding locums, the practice manager identified not only the cost benefit, but also the cost savings relating to quality and continuity of care that a NP provides, such as the need for general practitioners to review records and tests undertaken by a locum. She stated:

It's often financial analysis around the costs of a locum who would provide the same sort of care ... There's studies out there on locum care and what quality of care is provided by locums because they come in and don't know the demographic, the history. If they don't know the patient they're really not invested, that is just how it is. But we can't get away from using locums. Every clinic throughout New Zealand needs locums, however if you can have a nurse who is able to do that [work] but also has the ability to recognise "Actually I saw this child", or "Yes, I know this family" ... I'll follow you up in a week and a month and in a year. So, if you compare her to the costs of a locum, she's giving better clinical care, better follow-up care, and she's still going to be there in a year to actually see the patient again when they re-present at a third of the cost of a locum. It's substantial. (Practice Manager 2)

In terms of acute care, the practice manager identified a cost benefit to the practice, as well as continuity of care. She explained that when patients attend for an acute same day appointment the previous model of care was where patients are seen initially by the RN for triage and then by a general practitioner. The patient is charged for a single consultation. Instead a NP could offer one consultation and provide the appropriate follow-up care.

When asked about further texts that supported the practice to make changes to employ a NP, the general practitioner identified that they had a "lot of support" from both the PHO

and DHB, primarily through financial incentives. However, when I probed further and asked specifically about the key messages he received (the texts and discourses) that perhaps challenged the growth of the NP workforce, such as from the New Zealand Medical Association, the Royal New Zealand College of General Practitioners, or articles in *New Zealand Doctor*, the general practitioner replied:

I don't think I can comment on that really... but what the rest of primary care outside [our area] thinks about NPs, I wouldn't really know. For me it's obvious, the same as in a hospital. You know, you phone up, you've got an eye problem, you talk to the eye nurse. Well I'm quite comfortable with that, and if she can't help me she says: "Well, I'll speak to the consultant". I'm comfortable with that. It's just the way we're going to have to go. And I think it's good that we're going that way. (GP)

The lead general practitioner, with the practice manager and NP, appeared to be enacting only those texts that supported the development of the NP role in practice. These texts included those based on the general practitioner's previous work overseas with NPs, texts relating to the purpose of the work of general practices, and texts with attached funding from the DHB and PHO to reduce health inequalities, develop the nursing workforce, improve long term conditions management, and increase access to rural and Māori populations.

## **Nurse practitioners working in the public sector**

The majority of primary health care services are provided by general practices owned by general practitioners. However, several of the primary informant NPs were employed in the public sector, by DHBs or PHOs. New Zealand is a small country of 4.8 million people. Yet in the country there are 20 DHBs and 32 PHOs. These DHBs and PHOs are governed by the same authoritative texts produced by the Ministry of Health. Yet, the lack of centralised

implementation policy for primary health care services has led to a great diversity of models across the country (J. Smith & Cumming, 2009). Funding models were found to be largely tied to general practitioners and not sufficiently conducive to supporting nurses working in innovative ways, nor to supporting the employment of NPs (Finlayson, Sheridan, & Cumming, 2009). Within a neoliberal policy framework, the argument could be made that innovation should result. While there are examples of innovation, equally there is an overall sense that the Primary Health Care Strategy (A. King, 2001) did not sufficiently challenge the status quo to prevent the health sector from continuing as it always has done.

### **District health board owned primary health care clinics**

Ellie applied to work as a rural nurse, with the intention of completing her master's and gaining registration as a NP. She understood she was appointed on this basis. She received funding via the DHB to complete her master's, and the DHB helped with printing and binding her portfolio to be submitted to Nursing Council. The texts coordinating her actions and experiences from the DHB were authoritative and positive. But a new set of discursively mediated texts entered her social world when she was authorised as a NP and tried to gain employment. Ellie found the process to become employed as a NP both challenging and time consuming. It took six months from the time she was authorised as a NP to being employed as a NP. During those six months she continued to work at the same rural health centre, but as a RN.

The map opposite (page. 239) illustrates the sequence of text-work-text that Ellie described and experienced. Referring back to the scaffold map, the map below depicts the process from S8 to S9.



Ellie had anticipated she would need to discuss her new work as a NP when registered, but had not been prepared for the extent of the process. However, she did have a particularly supportive charge nurse manager, who herself had completed a master's, had a good knowledge of the value of NPs, and helped guide her through the proposal for a NP. Having submitted the business proposal and job description to the DoN, Ellie was surprised to find that there was no funding available for a NP position in that area. This was in stark contrast to her earlier understanding and the previous support received from the DHB.

She described the meeting with the DoN and rural health manager from the DHB:

I don't recall it as being a very pleasant experience.... The DoN came down with another bone of contention. She was upset that I would only want to work part time and not full-time... But there's not a role for a full-time NP – that would be ludicrous.... I sold my business plan that I felt for our population was justified. One FTE of prescribing, so that was my business plan proposal [0.5FTE general practitioners and 0.5FTE NP]. (Ellie)

Due to the rurality of the clinic, Ellie was not in a position to travel and work elsewhere, as the DoN requested. She lived (and worked) on the family farm in a rural hilly area of New Zealand, travelling 20km mostly on a gravelled track to the clinic. The closest medical centre to the DHB clinic was a further 85km away, and hospital services nearly two hours away. While the clinic required another authorised prescriber, a full-time role for a NP alongside the existing general practitioners could not be justified. Ultimately, Ellie's proposal for a 0.5FTE NP was accepted. Following advertisement and interview, Ellie was appointed as a NP in the rural health clinic.

For Ellie, the most surprising aspect of this part of her journey to become a NP was the apparent change in the DoN's support for her to establish a NP position. As part of her contract as a NP, Ellie had been asked to provide strategic lead to the NP development in the DHB, yet after twelve months this had not materialised. From Ellie's standpoint, it was

the DoN who was failing to enact those texts to implement a NP workforce. However, DoNs, employed by DHBs, themselves sit within a highly complex web of ruling relations, enacting texts from a range of potentially competing interests. Such texts will include the DHB annual plan, based upon the Ministry of Health's expectations and requirements, the local health needs, and finance; discourses of professional nursing and primary health care; and nursing priorities for workforce and career development both in and out of hospital.

Leanne had worked as a rural nurse specialist for many years, covering out of hours work for general practitioners and working in rural and remote clinics. She had a wealth of experience, and in addition to her master's papers had undertaken a range of other advanced clinical courses. Towards the end of her master's she commenced working in a DHB rural nurse-led clinic. The clinic was supported by a locum general practitioner who covered several rural clinics over a large geographical area and visited Leanne's clinic once per week. She was required to work largely autonomously, dealing with major trauma, as well as the full range of general practice and community nursing work. When approached about the rural nurse specialist job:

I thought, I've got to go [and take the job]. I can do one job doing everything. You're the LMC [lead maternity carer], the well child provider, the public health nurse, the school nurse, district nurse, the PRIME [emergency] practitioner, oncology - you name it. (Leanne)

The difficulty in recruiting more permanent general practitioners, and even longer-term locums was problematic. Leanne understood that the DHB wanted to employ NPs to this remote area. On completion of her master's she had a conversation with the DoN:

They [the DHB] talked about having a NP in the hub and I said to the DoN "Now I've done my master's. I want to become a NP and I was led to believe that these positions were actually NP positions", and she said "Well no. You have to apply for a job and it depends on your suitability. There might be a job at [somewhere far away] for you. And that was that - I thought well - and

one of the [nurses] even said, “So you support your staff to do the course but as far as becoming a NP, actually providing that position for them, that’s not an option”... It was the circumstances there that pushed me to resign.

(Leanne)

As with Ellie, and indeed Liz (see chapter five), the nurse believed she had aligned her goal to become a NP with the goals of the DHB, which she had understood was to employ NPs instead of locum general practitioners, and the needs of the community, yet the discourse changed from the DoN. As with Ellie, Leanne did not understand this about turn. Sadly, it was on the basis of the discussion with the DoN that led Leanne to begin to negotiate a NP candidate position back in her home town, where she has now worked as a NP for several years.

### **Carol’s work in a PHO**

As with the efforts that had been required to gain employment, many of the NPs faced ongoing challenges in their place of work. Carol was employed by a NGO health provider which provided services to high needs and Māori populations. The services reached across a wide geographical area from the edge of a town with a general hospital to rural communities over 1.5 hours away. Part of her work when she was employed was to establish NP services in areas of need. From her knowledge of being an experienced NP, and working within a social justice framework to reduce health inequalities, Carol commenced work on several areas which warranted NP services. Carol’s map (on page 244) shows four different streams of work. The map is simplified. Not all text-work-text sequences are shown. The intent of the map is to demonstrate not only the work done, but texts which were identified by Carol in the interview as well as potential texts which were not fully visible to her.

Carol described how her work embracing both biomedical and social justice models was likely to improve health outcomes:

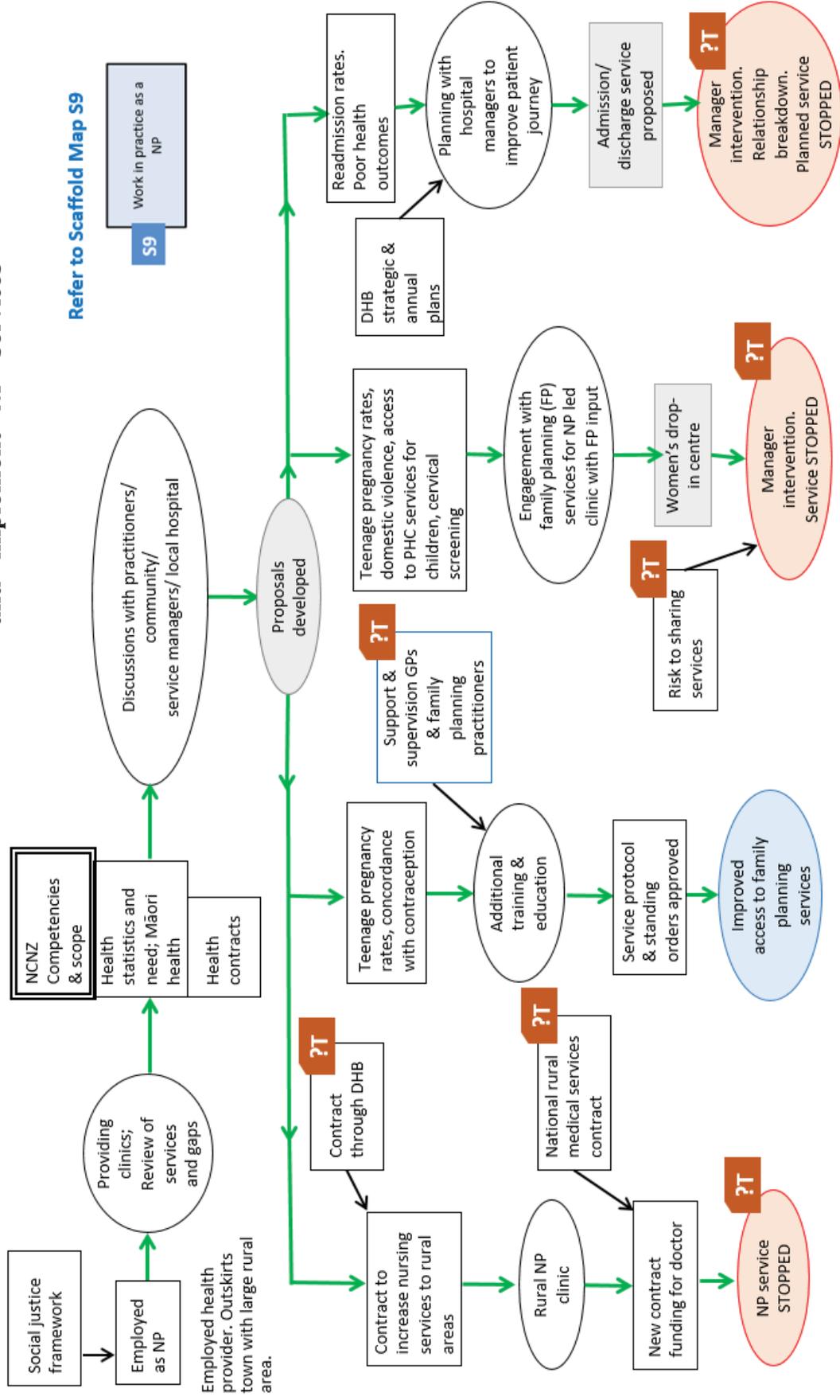
A lot of the disparities lie in accessing health within the Māori communities... If you have a NP who is connected with the local community, then you actually supply a conduit between accessing health and health status.... Key health issues have been identified [by me] through whānau and communities. It has been because I've been there and working with the community ... and addressing needs as they have arisen.... [Being a] NP, especially with prescribing, is invaluable in those areas. (Carol)

Carol expressed a strong sense of frustration regarding the difficulties she experienced in establishing NP services. On two occasions she had begun working in a rural clinic as a prescribing NP with a practice nurse in support. The NP position was funded through a contract via the DHB to the health provider, to support the development of advanced nurses. However, another contract to support the employment of doctors in areas with a high Māori population led to her being replaced by a doctor:

They have funding for Māori medical officer support and they didn't want to let that funding go, so they've chosen to continue with the funding and get doctors in, and that's eaten away at the potential for the NP role to develop. So I'm left with just part-time clinics, some admin work, supporting student nurses and the new registered nurses on the block. (Carol)

Carol

Map 13: Carol to develop and implement NP services



In one work stream the NP developed a women's health service. She worked with another NP who was employed through the secondary hospital services. A project plan was developed where women could be seen and supported, screened, treated and managed, and if required, advice would be sought from the specialist NP via skype during the clinic. Hence a one-stop-shop service. The need for this service had developed from the NP's knowledge and experience of the community, information from New Zealand statistics, and research both from New Zealand and overseas. She stated:

I wanted to set up a women's drop-in centre in one of the rural areas because they have a lot of family violence and rape. They get pregnant because they can't afford the \$10 fuel to get into town to get any contraception, they can't afford a prescription anyway. So they just keep getting pregnant and then they've got all these kids. They can't say no to the partner, because they'll get beaten up. So there's nowhere to go, nothing to do ... except get pregnant and have kids. It's not that they want to have all these kids, it's that they haven't got any alternative. And what I wanted to do was set up a drop-in place where women could come, have a cup of tea, cup of coffee, listen to music, have a chat, get some contraception, get some health screening, get some STI screening, get their kids immunised, make a cake, you know, it was going to be a 'woman's place' not a women's refuge, but a drop-in place. (Carol)

The solution and proposal was evidence-based and adapted to meet the needs and fit the resources within the local community. A change of manager at the health provider resulted in this project being "completely quashed". Health providers, including Māori providers, are non-governmental organisations (NGOs) that grew from communities to support specific health and social needs. The advent of New Public Management within the neoliberal policy framework from the 1990s has led to a complex contracting environment (Gauld, 2009) where NGOs can bid for funding from both health and social funding streams. Lance

O'Sullivan, a Māori general practitioner from Northland explained the tensions in his book, *The Good Doctor: Breaking the Rules, Making a Difference*:

The need for contracting turned these simple organisations into complex ones – and I believe that's what set Māori health providers on the path to becoming like mainstream providers. Contracts are prescriptive and it doesn't make a lot of difference which organisation is bidding for them. They limit the opportunity for Māori or any other ethnic group to find their own solutions to the issues which their own communities face. (O'Sullivan, 2015, p. 118)

The result is general managers who may not have a social or health professional background and who are competing with often multiple other organisations, including PHOs, to acquire funding. Further, the contracting environment requires reporting on the contracts to the funder (DHB, PHO, Ministry of Health, or Ministry of Social Development) often quarterly. Managers face pressure from health and social work professionals, from their governing boards, from their funders, and also from their communities. However, the NP did succeed in establishing a service to provide contraceptive implants. This stream required input from general practitioners, local family planning services, further education and training, and ongoing supervision. The work done to achieve this was considerable.

Finally, because of her “potential to develop services ... and to network”, Carol linked with a nurse specialist from the hospital to identify patients with planned admissions, and any discharges to improve the patient journey, and reduce admissions. She described this as a direct link with the hospital, and yet at a senior level between managers the relationship broke down. When commenting on the difficulty of developing services, Carol said:

I don't think that [the organisation] didn't want it [the proposed service] to happen. They didn't know what to do with it.... They didn't have my insight, they never had my focus, and they never had my ultimate aim in mind. (Carol)

Carol is describing the multiple texts that are circulating, for various managers in their different organisations. In many ways, these competing texts lead to inertia and perhaps the inability to enact any. From her perspective, the NP can identify the health needs and how to provide services to meet those. She is already employed, with her salary paid, however, the organisation does not have the same view or insight. This disjuncture highlights the failures of the organisations involved to improve access to health.

Throughout the interview, Carol raised concerns about her role as a NP not being well understood by the health provider, some senior nurses, and general practitioners:

The NP role in NZ seems to have been created from a need, rurally, but it hasn't been supported and publicised very well.... [If this had happened] the people in the health sector would understand what that role is and where it's coming from. (Carol)

Nurse practitioners are required to demonstrate the actualities of the concept of the NP role. They need not only to describe, but also to show the work that they actually do through their practice. Further, they need to undertake the work exploring how they fit into the current organisation, delivering services to meet the health needs of the population. The process to develop collaborative practice is slow (Schadewaldt, McInnes, Hiller, & Gardner, 2013). Further, as identified in a study in Ontario, the rapid changes in the primary health care sector creates a complex health environment where organisations are "ill-prepared" to receive NPs (Sullivan-Bentz et al., 2010, p. 1176)

Since the interview, Carol has reported that she feels she is now making significant strides to establish inter-disciplinary and inter-agency work within a high needs community. Carol's work has spanned more than five years. She has been committed to working collaboratively to ultimately increase access to health services. In Saskatchewan, NPs were identified as being central to improving the coordination and integration of primary health care (Quinlan & Robertson, 2013). Further, a participatory inquiry in British Columbia

revealed “the inherent capacity of NPs to champion collaborative relations at all levels of the health system and thereby foster role development” (Burgess & Purkis, 2010, p. 303). Carol’s work exemplifies the possibilities of the NP workforce.

## Summary

Carol, perhaps, summed up the sentiment of my thesis:

The country needs to realise how good NPs are, how useful the role is, and how beneficial it is to health services and especially to people in low socio-economic groups who have health issues around poverty and everything else they’ve got going on. They need to know that the NP, especially with prescribing, is invaluable in those areas. (Carol)

Carol’s work in an area of significant deprivation, and predominantly Māori showed her commitment to work within a social justice paradigm. Health inequalities remain unacceptably high in New Zealand, and there is more than enough work for health care professionals in rural and deprived areas. Yet often, the work of NPs is limited by other priorities that are materially enacted in their local environment, such as contracting arrangements, funding, and at times the ongoing discourse of the need for general practitioner-led services and the dominance of biomedicine. Within the fragmented health system, competition between organisations to acquire and retain contracts becomes the focus of work processes. The health needs of the local community are often diminished through these processes as the organisations seek to serve their own interests of sustainability.

The exemplars given in this chapter begin from the standpoint of the NP. The NPs often described the experience of their consciousness being bifurcated. They had their vision, beliefs, and professional values of how a NP should work, and yet were constrained by more powerful texts, often without their knowledge. Alana and Elaine described how their

referral letters to certain medical specialists were rejected without adequate rationale. While a number of texts might be circulating, including the information systems, it appeared that the medical specialists were enacting the historical texts that patients had to be referred to specialist services by general practitioners. The Senior Medical Officers' forum revealed their perpetuation of the discourse challenging NP's length of training and competency without taking heed of evidence (as discussed in chapter six). Ultimately, the patients' best interests were not being served, but rather the medical profession were working to maintain their ongoing dominance for their own interests.

The over-use of locum doctors in rural primary health care continues with very few NPs being employed. However, there is a small indication that the momentum is changing, both in terms of the growing numbers of NPs, and in the recruitment of NPs as locums. The exemplar describing the general practice in which Jane transitioned and worked as a NP, is testament to a model that aimed to employ more NPs rather than rely on locum doctors. This practice demonstrated how they enacted texts to provide the most appropriate health care for their community and texts that promoted the development of the primary health care nursing workforce to optimise scopes of practice.

Both Ellie and Leanne described their expectations to become NPs and how their pathway had been supported by the DoNs of their DHBs. Yet both experienced an about turn in the decision to appoint them as NPs, as other more authoritative texts were instead enacted. While Ellie pursued her fight to become a NP in the practice, Leanne left and developed her work as a NP in a health clinic in a small rural town. The opportunity to employ Leanne as a NP to deliver full primary health care services, which were otherwise not available in the remote rural area, was lost.

Given the evidence on NPs' value, effectiveness, and costs in rural primary health care, to invest in rural NPs would seem a highly rational choice for the New Zealand Government. Despite the ever-decreasing general practitioner workforce, and the costs and

disadvantages to health care of employing short term locum doctors, the texts perpetuating general practitioner-led primary health care services are enacted across general practices, NGO health providers, PHOs and DHBs. There are multiple texts circulating within a complex and fragmented primary health care health sector that have in some way thwarted the establishment of NP services in some of those localities in my study. However, there are also examples of the ongoing work of NPs, and others, to establish collaborative primary health care services, and working within the best interests of individuals, their whānau and communities.

# Chapter Eight

## Discoveries and Implications

### Introduction

The final chapter has been entitled 'discoveries and implications', rather than using the term conclusions. In IE there are often no definitive conclusions, and the term 'discoveries' might be more appropriate (Griffith & Smith, 2014a). Institutional ethnography is used to develop our knowledge of the extra-local or ruling relations that permeate into our everyday lives beginning with a particular area of focus. Griffith and Smith describe how early in the development of IE, they were surprised to discover how much could be learnt across institutional settings, from tertiary education, schooling, municipal development, and hospitals. The discoveries from my research add a further snippet to the growing international collection of institutional ethnographies which explicate how the ruling relations of our current global and political systems are textually coordinating the everyday lives of individuals, often struggling in their everyday worlds.

Nurses undertake the journey to become NPs in good faith. They see the health disparities that their communities are experiencing, the level of socio-economic deprivation, and the resulting hardships their families and whānau face. They identify that rural and deprived populations have difficulties in accessing health services and challenges in navigating their way through health and social systems. They hear of the rural general practitioner workforce crisis, and read government policy to reduce health inequalities and provide integrated health services close to people's homes. They believe that the NP role will offer a service to local communities that will improve their health outcomes. Although their passion and commitment is often extraordinary, they find the journey to become a NP is challenging.

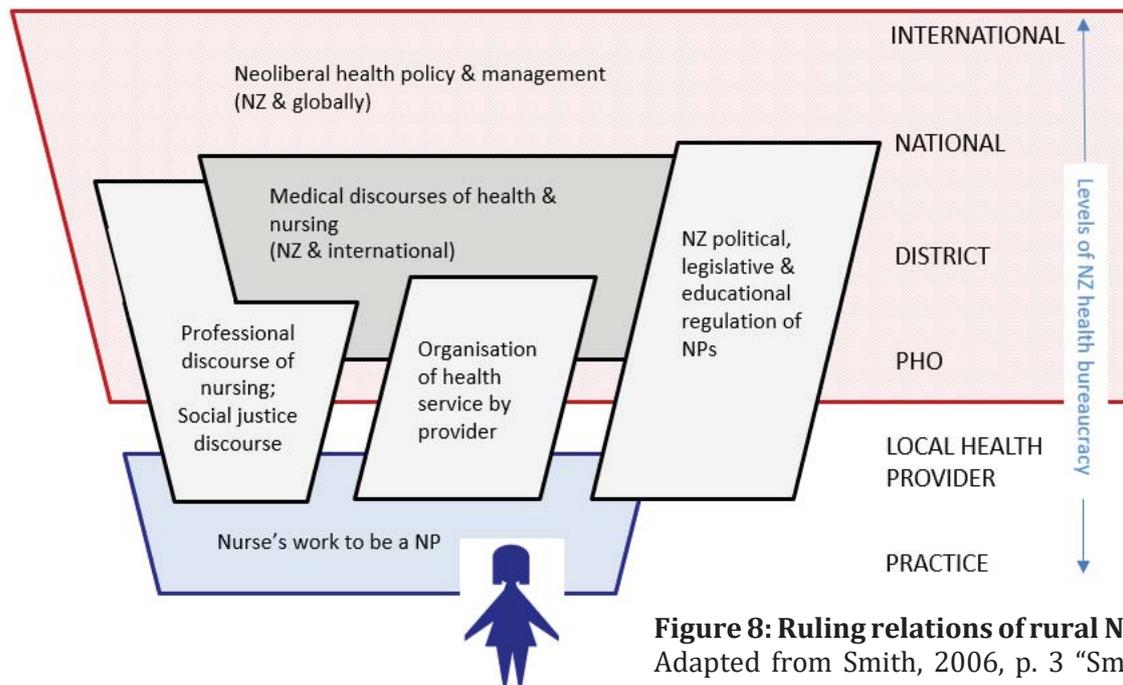
The research presented in this thesis aimed to critically examine the work required to establish NP services in rural primary health care in New Zealand. The research questions explored were:

- How do nurses and NPs describe their experience of becoming a NP, gaining employment, and delivering NP services in rural New Zealand?
- How is their experience textually shaped and organised in their local settings?
- How are institutional texts and discourses coordinating and controlling the development of the NP workforce in New Zealand?

Using IE as the approach to inquiry (Smith, 2005), the research began from interviews with primary informants, the NPs and NP candidates, mapping text-based work processes using an analytical method described by Smith (2006a) and Turner (2006). From these interviews, texts were traced and mapped to show how their experiences and actions were textually mediated in the local setting. Further analysis, through particular disjunctures, explored how the institutional texts and discourses were directly controlling the development of the NP workforce and impeding the establishment of rural NP services. At the same time, those who had successfully become authorised as NPs identified aspects of their journey that were facilitative.

Returning to Smith's (2006b) "small hero" figure (Figure 1, shown on pages 14 and 105), I have adapted this further to show how the NP in her practice setting is being connected or hooked up into the institutional ruling relations (see Figure 8 opposite, page 253). These ruling relations, exposed through the data analysis of this inquiry, have organised and coordinated the work, actions, and experiences of the NPs and NP candidates. I have chosen to leave the "small hero" as female as all the informants in this inquiry were female, as are more than 90% of NPs in New Zealand. The New Zealand health sector is fragmented and hierarchical. Texts and discourses are variably enacted from the national level through

bureaucratic layers to the local level. Further, the textual environment of the sector changes with some regularity. Nurse practitioners and NP candidates engage with multiple texts entering into their local setting. The various experiences of the primary informants show the complexity of the environment and without a national strategy to implement NPs, the establishment of the NP workforce will continue to be ad hoc.



**Figure 8: Ruling relations of rural NPs**  
Adapted from Smith, 2006, p. 3 “Small hero” figure

In the final chapter of this thesis the key findings arising from the research are presented and discussed. The intention is to provide understanding of how things are as they are, providing the opportunity to consider what is needed to promote the growth of the NP workforce.

## Nurse practitioners: “Hiding in plain sight”

“Hiding in plain sight” was used by Glenn Gardner<sup>61</sup> to describe the invisibility of the advanced practice nursing workforce in Australia (Gardner, 2016). Gardner, as did Naylor

<sup>61</sup> Glenn Gardner is Professor of Nursing, Queensland University of Technology, Brisbane, Australia.

and Kurtzman (2010), emphasised that NPs were a solution to contemporary health care issues, but their contribution has been largely overlooked by policy makers, stakeholders, and the public. The reports of the Institute of Medicine (2011), the WHO (2008, 2009), and the All-Party Parliamentary Group on Global Health (2016) described the necessity of utilising advanced practice nurses to manage the growing burden of health care, due in particular to an ageing demographic, increasing prevalence of chronic illness, and ongoing health inequalities. Internationally, the NP workforce has successfully provided services to underserved, marginalised, indigenous, and rural populations (DiCenso et al., 2010; Everett et al., 2009; Hansen-Turton et al., 2010).

There is a substantial body of evidence validating that NPs have similar biomedical clinical competencies, prescribing practices, and achieve the same or superior health outcomes to general practitioners (see for example: Dierick-van Daele et al., 2009; Gielen et al., 2014; Martínez-González et al., 2014; Pirret et al., 2015; Swan et al., 2015). In the literature this is referred to as equivalent practice to doctors, and often the term substitution is used. Group and Roberts (2001) make the point that NPs have to continuously demonstrate their effectiveness and quality of care, yet medical practitioners do not face the same level of scrutiny. While arguments can be made that NPs offer more than just the substitution of medical tasks (Carryer & Adams, 2017), evidence demonstrating NPs' effective and safe practice should provide adequate assurance for policy makers, managers, and doctors.

For sixteen years, NPs have been struggling to gain acceptance and become a significant provider in the New Zealand primary health care workforce. There are now approximately 125 NPs authorised and working in primary health care in New Zealand. Since embarking on this study, there has been a recent increase in the numbers of nurses registering as NPs, particularly following the introduction of the Nurse Practitioner Training Programme funded through Health Workforce New Zealand (HWNZ), and run by Massey University and the University of Auckland since 2015. The Nurse Practitioners New Zealand survey,

collected in October 2016 from 124 NPs across all specialities, found that over 90% were prescribing on daily basis. However, 33% identified that their role as a NP was functioning to its full potential either “partially at times”, or “not really” (D. Williams, 2016).

The general practitioner workforce issues have been repeatedly raised both in New Zealand and globally. Since the late 1990s, New Zealand has implemented a range of funding schemes to attract and retain general practitioners in rural areas. Apart from some individual practice successes, overall, the rural medical workforce has continued to decline in numbers, and is likely to continue to do so with more general practitioners approaching retirement age (Goodyear-Smith & Janes, 2007; Royal New Zealand College of General Practitioners, 2015). Yet institutionally, the fall-back position has been on how more general practitioners can be recruited and retained.

Through this study, examples were described where the locum general practitioner workforce took precedence over the employment of a NP in a DHB clinic. Despite Leanne being supported to complete her clinical Master’s in Nursing by the DHB, the DHB continued with its model of employing locum doctors after she had become a registered NP. General practitioners at a DHB owned general practice, when offered a NP (Shona) to work as a locum for a short period of time, refused to work with her. While Shona has since returned to the practice as a locum NP, the DHB has persisted with the locum doctor model, at considerable cost to the DHB, rather than utilise permanent NPs. Despite the communities’ needs for general practice services, the NPs were essentially invisible to the DHB nurse leaders, policy makers, and funders.

The purpose of the senior medical officer’s forum was specifically to discuss the potential of the NP workforce. Four NPs were invited and were present at the forum. Following a presentation by a senior academic, the conversation moved from doctors who had experienced working with NPs and positively acknowledged their contribution, through to the disparagement of NPs, including providing misinformation, and ultimately to a

discussion on how more general practitioners could be trained and retained. The NPs at the meeting were completely invisible as a solution to local health workforce needs.

The New Zealand Health Strategy, *Future direction* (Ministry of Health, 2016c), mentions general practitioners (GPs) on five occasions, but there is no mention of NPs. Ministry of Health press releases, where general practitioners and NPs could be used interchangeably, only ever refer to general practitioners. One NP in the study noted that there had been no information provided publicly to the population of New Zealand to explain the role of the NPs. Nurse practitioners do not always feature on the signage of general practices, nor on their websites. As I complete this thesis, Paul Goldsmith, the Minister of Tertiary Education, Skills and Employment, announced that a School of Rural Medicine was to be established (Goldsmith, 2017). In discussions played out in the national and professional press, NPs have at no point been raised as a potential solution, despite submissions from professional nursing and NP organisations. Ultimately, the NP workforce is indeed hiding in plain sight.

## **Social justice and health policy: A disjuncture**

In 2014, Jonathan Coleman, was appointed as Minister of Health. Coleman trained in both medicine and business, and worked as a general practitioner. The briefing he received stated:

To respond to the changing burden of disease, the health and disability workforce will need to work in different ways. There will be greater emphasis on working with a wider range of colleagues (within the health sector and the broader public services including local government) and partnering with individuals, their whānau and communities to ensure services are delivered in a way that meets people's needs. The changing needs of people with long-term conditions require a workforce prepared to provide services that include coordinated care plans and a higher number

of contacts. It will also mean a greater focus on wellness and prevention in addition to treating acute episodes. (Ministry of Health, 2014b, p. 9)

Globally, there has been an increasing call that a new model of primary health care is required to meet the health needs of the population (Commission on Social Determinants of Health, 2008; WHO, 2008). The briefing statement to the incoming minister aligns to a model of care that is not located solely within the biomedical model, emphasising meeting health needs, partnering, coordinating care, and a focus on wellness.

Through my interviews with the primary informants it became increasingly evident of the disjuncture between their reasons for becoming a NP and their reality in practice. NPs spoke strongly about their connections to their local communities, including their work to develop services that responded to the local health needs. For the past several decades there has been rhetoric within New Zealand health policy regarding the need to reduce health inequalities. The Primary Health Care Strategy (A. King, 2001), signalled a time to change models of care and take a population and wellness approach to health. Annette King, the Minister of Health during the early 2000s, further identified the possibilities for the NP workforce to reduce health inequalities and deliver on the purpose of the Strategy (F Hughes & Carryer, 2002).

Tertiary education institutions implemented clinical master's programmes based upon the Nursing Council's required educational standards. These authoritative texts had been developed through engagement with nurses, nurse leaders, and researchers, both in New Zealand and overseas. Educational programmes were developed to deliver biomedical knowledge for advanced assessment, diagnosis, and prescribing to meet the NP competencies. Further competencies required NPs to deliver needs-based community services, that were culturally safe, promoted equity, and collaborated with health and other community service providers. Ultimately, the NP scope of practice utilised a social justice

framework with the ability to provide biomedical care and prescribing. These texts created a professional nursing discourse of the value and importance of NPs in New Zealand.

The NPs and NP candidates in this study identified the disjuncture between the professional nursing discourse of rural NP work and their experiences and difficulties in implementing NP services. Smith (2005) would describe this as a bifurcation of their consciousness. They experienced feeling frustrated or angry, and at times were left bewildered and confused. They had taken the authoritative knowledge produced institutionally and worked to implement these texts into practice. However, other texts and discourses often proved to be more powerful in their local setting. Alana described a referral to a medical specialist that led to a series of additional text-based work processes in order to meet the needs of a particular patient. She could not reconcile how her professional knowledge was being undermined to the detriment of the patient's health. Liz described a lengthy journey, that required her to change employment on three occasions. She had the intent of delivering NP services to people with long term conditions living in deprived, and predominantly Māori, rural communities. Yet powerful competing texts relating to the structure of the health sector entered into the local setting and ultimately prevented her becoming a NP. Carol described her work to implement several NP led services based upon the health needs of the local community. The services completely aligned with the intent of the Primary Health Care Strategy. Despite extensive work with the community and other service providers to develop the services, some plans were completely quashed by the health provider's management.

The journeys the primary informants described were enormously variable, echoing the findings of an earlier publication by Carryer et al. (2011) of the *ad hoc* process experienced by rural nurses. Some of the NPs described examples of considerable support from colleagues, general practitioners, and local nurse leaders, that facilitated their activities to practise as a NP. From interviews with secondary informants in these localities, it was

evident that the texts promoting services to improve access and reduce inequalities, utilising the NP workforce, were given power and enacted in the local organisation and/or practice. In these localities, there was no sense of competition between NPs and general practitioners, only that there was a need to provide health services to a community, and NPs were a committed, long term workforce, that could provide such services. As one general practitioner said, “there is more than enough work for all of us”.

## **The primary health care sector: Shifting sands**

New Zealand is a small country of 4.8 million people. The health bureaucracy is extensive with twenty DHBs, 32 PHOs, over seventy Māori health providers, in addition to Pacific health providers, and multiple health related non-governmental organisations. All of these organisations may provide primary health care services to individuals, whānau, and communities. Changes to health policy, structures, and particularly planning and funding arrangements, have occurred with some regularity in New Zealand over the past three decades. The cost of each reform has been considerable (Cumming, 2015), yet there is little evidence to suggest that the macro level changes have made much difference to the way services are delivered to patients in primary care (Cumming, 2011). Additionally, New Zealand is a small country which presents both strengths and weaknesses. In one respect, change can be made quickly, yet all too often that change is reversed without adequate evaluation (Cumming, 2015). Individuals can be afforded positions of power making swift changes to policy implementation as they see fit, with little regard to existing projects or evidence.

The primary informants in this study provided examples where structural or policy changes to the health sector occurred. Liz (see chapter five) described how her efforts to become a NP had been caught up in national and local health policy change. Firstly, the CEO of the DHB changed his position on supporting the NP, arguing that the primary health care sector

needed to lead the development of NPs. Secondly, a change in health policy, following a newly elected National government, led to the consolidation of PHOs in the area. The enactment of this text directly affected Liz on her journey and resulted in her changing employment again. The small, local PHO where Liz had been employed to complete her registration as a NP, was merged with a larger, out of area PHO. A change in policy resulted in lack of support for the development of a NP workforce. The merger of the PHOs led to considerable tension between the DHB and PHOs. Consequently, the DHB decided they would support Liz to become a NP. The local environment changed yet again, and the DHB made an about turn on their decision to support Liz. Liz's work and experiences were connected up with the national institutional changes in policy that in turn created texts and discourses that competed with Liz's work to become a NP.

Carol described how she was working in a rural clinic as the sole NP, employed by a local Māori health provider. A contract providing funding to support the employment of Māori doctors to rural areas from the Ministry of Health was enacted by the health provider's manager. The NP, who was committed to working at the clinic long term, was replaced by a series of locum doctors. The contract, giving additional funding to the health provider, proved more powerful than texts promoting, for example, continuity of care. Ellie, Shona, and Leanne, all worked in rural clinics, maximising their scope of RN practice, due to limited access of patients to general practitioners. Their DHBs supported their work to become NPs. Having become authorised NPs, each was subjected to what were apparent changes in local DHB policy. These texts were not visible to the NPs, nor available publicly.

District health boards (DHBs) have the responsibility for planning and funding many (but not all) primary health care services. There is no legislative requirement for DHBs to determine *how* local primary health care services are delivered, nor do they have any accountabilities to develop the primary health care nursing workforce. This lack of clear policy direction for the development of NP services has resulted in NPs often being caught

between competing texts. Tenbensen et al. (2008) critiqued the role of DHBs in delivering national health policy goals, including the Primary Health Care Strategy:

Overall, DHBs demonstrated the 'will' to engage in strategic decision-making processes to enhance population health but have difficulty in finding the 'way'. The priorities and requirements of central government and the weight of institutional history were found to be the most influential factors on DHB decision-making and practice, with flexibility and innovation only exercised at the margins. This raises the key question of whether there is the governmental capacity at the local level to adequately address nationally determined population health policy priorities. (p. 1143)

The lack of an overall implementation strategy for the NP workforce has limited their development.

The story of physician assistants (PAs), which I discussed in chapter six, explicated two particular institutional processes: firstly, the power that individuals are given and are able to hold within an organisation (and often several organisations simultaneously); and secondly, how policy, both at a national and local level, can be changed rapidly, often on the basis of a particular whim. When I first made notes on this, I was interested in the extent to which the smallness of the country, where "everybody knows everybody", especially in the leadership positions in health, was an important factor. Corbett (2015) explored whether the smallness of self-governing countries across the Pacific resulted in a healthier democracy. Perhaps not surprisingly, the response was complex, identifying the value, for example, of having leaders so closely connected with family and community, and for the opportunities to have more organic political processes that engage with the population. On the other hand, Corbett identified how accountability can become blurred when individuals fulfil overlapping roles, and when power is concentrated on the individual, rather than the office they hold.

The chair of Health Workforce New Zealand (HWNZ), and Professor of Medicine at the University of Auckland, Des Gorman, established a pilot project to evaluate the role of the PA both in the acute hospital setting (phase I) and rural health (phase II). Despite the project receiving widespread criticism from both medical hospital specialists and the nursing profession, the project went ahead. There were four demonstration sites in rural primary health care settings at a cost of \$1.2 million. The evaluation report, completed in 2015, stated that PAs had the potential to negatively impact nursing, particularly at the “expense of the development of the NP role, ... undermining the[ir] holistic value” (Appleton-Dyer et al., 2015, p. 11). The PA workforce was not adopted in New Zealand.

The nursing profession were resentful of the attempt to introduce PAs. For NPs, there was a robust educational, regulatory, and legislative framework in existence, but nothing for PAs. The biomedical discourse appeared to dominate Gorman’s development of the PA project, however, he received strong criticism from his medical colleagues, as well as others, including the Health and Disability Commissioner. Gorman appeared to actively refuse to engage with a range of other national texts, and continued single-mindedly. Gorman had navigated himself into a position of power within the health sector in New Zealand, and in this position was allowed to proceed with a project amidst concerns from various professional groups and organisations.

Historically, of course, there are a multitude of examples where people are elevated to a position of power, and fail to act in the best interests of those they should be serving. In this position, they may return to historical discourses, adapt, or create new authoritative texts, which result in a change in power balance of the ruling texts. There is a meshing together of individual power with institutional power. In turn, a considerable amount of work is created for a range of people across the health sector, whether it is to contest the new idea, or to enact the policy changes. This diverts from useful time, work, and money that could be utilised to promote an existing NP workforce.

## Medical hegemony: A mixed bag

A distinction was made earlier in the thesis between primary care and primary health care. Throughout the thesis I deliberately chose to use primary health care, as NP practice is underpinned by primary health care principles (Kooienga & Carryer, 2015). Traditionally, *primary care* has been defined as the service provided by general practitioners, who are the first point of contact by individuals within the health service. This narrow definition does not encompass the requirements for health service provision, now nor in the future, where attention is required to reduce health inequalities and the burden of long term conditions, support an ageing population, and promote social justice. The term primary health care is seen throughout government policy, including the 2016 New Zealand Health Strategy (Ministry of Health, 2016c). However, in the main, this latest Strategy refers to the traditional concept of primary care and has little to offer to challenge the status quo. Part of the disjuncture experienced by NPs is their intention to enact primary *health* care but they are doing so within a social world mediated by primary care and biomedical texts.

Chapter six was entitled the “Contested Space of General Practice”. The experiences of the primary informants differed considerably, highlighting the variation and complexity of the local primary health care settings. With approximately 125 NPs working in primary health care now, there are many successful stories of general practitioners and NPs working collaboratively in practice. I described Jane’s story where the general practitioner owners had changed their model of employment in order to support the development of the nursing workforce, enabling Jane, and others in the future, to become a NP. Elaine described how she had worked with a general practitioner, engaging with texts that enabled her employment, and challenging those that didn’t. While it took a while to establish, the result was that Elaine provided similar services to the general practitioner for the local community. Shona described how she worked in a general practice, with her own caseload of patients. Carol described how after general practitioners had worked with a NP they

understood and valued their input. In these situations, the contested space no longer existed.

On the other hand, most of the primary informants described one or more examples in their journey to become a NP where there had been some contention of their work expressed and enacted by general practitioners. Of course, those interviewed who were NPs, had found their way around this by changing practices. One NP candidate described her considerable frustration when the general practice changed ownership, and the new general practitioner owner no longer wanted to support her to become a NP. She stated: "That's the paradigm. That's what we're up against" (Natalie). As noted earlier, Shona described how general practitioners first refused to have her work as a locum in their practice, yet ultimately changed their minds, accepting her work. Despite a shortage of general practitioners in rural primary health care, with 25% of practices having a permanent vacancy, NPs expressed bemusement at the persistence to maintain the locum doctor workforce.

General practitioner owned private businesses have dominated the provision of primary care for well over a century, following the colonisation of New Zealand. There is an inherent tension between owning a practice and delivering health services to meet the health needs of a population. Yet while there have been various opportunities for changing the model, the New Zealand Medical Association (NZMA) have acted as a political lobby group on behalf of general practitioners and resisted changes. Notably, these were, a refusal to enact the Social Security Act (1938) (consequently amended), where there was an opportunity for a universal and free service for primary care; refusals to accept payments to reduce user charges through subsidies, and capitation payments in the 1980s and 1990s (Barnett & Barnett, 2004; Gauld, 2009; Quin, 2009); and, ongoing high user payments (Cumming et al., 2008; Finlayson et al., 2009).

Through my inquiry it was evident that a considerable tension existed between the growing number of general practitioners who acknowledge the value of NPs, working with them as

colleagues, and those who continue to denounce NPs' potential contribution to the health workforce. As with any change, there are early adopters who understand the rationale, and use existing policy and funding mechanisms to successfully employ NPs, and those who continue resist change. By tracing texts beginning with the New Zealand Doctor magazine, circulated to the majority of general practices, I explored the tensions playing out in the various articles on NPs and the feedback received and published.

The professional medical associations in New Zealand and elsewhere in the world remain a powerful political force, retaining their hegemonic position in the development of health services. Nurse practitioners remain a gendered profession where medicine continues to claim to be the "only profession expert enough to judge who should do what in the production of health" (McMurray, 2011, p. 806). The textual evidence from the medical professional organisations in the US and Canada showed how such arguments to retain medical dominance in the health sector were continuing despite years of having a substantial NP workforce in their countries, with a substantial evidence base to support the NPs' work. These discourses, of a biomedical model of primary care, maintain the current health system as being doctor-led and medically focused. The result is that services do not reach all those in need, and the communities most disaffected by western medical service delivery models continue to experience unacceptable health inequalities. However, the tide appears to be turning and each year more general practices and primary health care provider organisations are supporting and employing NPs.

## **Neoliberalism versus social justice**

Medicine has been a powerful institution for well over a century, and the responsibility for providing healthcare to individuals and the population has largely been claimed by the medical profession (Freidson, 1970; Group & Roberts, 2001). Paradoxically, the current western model of medicine, particularly within a consumerist neoliberal political system,

has been challenged as perpetuating inequalities in health (Camargo Plazas, Cameron, & Smith, 2012; Collyer & White, 2011; Peacock, Bissell, & Owen, 2014; Rylko-Bauer & Farmer, 2002), particularly for indigenous populations (M. King et al., 2009; Woodward & Blakely, 2014), and for those with long term conditions (Martin & Peterson, 2009). Globalisation of health has been identified as a product of the expanding medicalisation of society, and of neoliberal capitalism (Rieder, 2016). While opportunities exist for benefiting the health of the world through globalisation, there is increasing concern that globalisation is creating health risks and contributing to widening inequalities in health (Frenk & Moon, 2013; Haynes et al., 2013; Labonte & Torgerson, 2005).

Māori experience health inequalities at an internationally unacceptable level, despite what has been considered substantial progress in health over these past few decades (Blakely et al., 2005; WHO, 2008). Attending to health inequities and promoting social justice are human rights issues (D. Wilson, 2013). Complexities, including land ownership and rights, and a disconnection from land and often spiritual roots, have resulted in Māori being marginalised and politically powerless (D. Wilson, 2013). Māori models of health and wellbeing are at odds with the Western biomedical model of health, and health services often do not reflect the social and cultural context of Māori.

Despite the rhetoric in New Zealand to address health inequalities, particularly for Māori, broader strategies rarely make it onto the political agenda resulting in little sustainable change (Embrett & Randall, 2014). The WHO describe that health and equity are not automatically prioritised over other policy objectives:

In our interconnected world, health is shaped by many powerful forces.... Policies designed to enable people to lead healthy lives face opposition from many sides. Often they are challenged by the interests of powerful economic forces that resist regulation. Business interests and market power can affect the ability of governments and health systems to promote and protect health and respond to health needs. (WHO, 2013, p. 1)

The tension between the goal of *Health for All* through a social justice paradigm, through the provision of primary health care services, and the dominance of global neoliberal capitalism is evident through the data. These powerful texts often act in opposition to each other in the local setting. One Māori NP described how she was determined to overcome the knocks and barriers, and that no one could take away her vision. She said “I was going to be a NP, and I was going to make a difference for my community. End of story” (Informant 4, Group 2014).

At the heart of reducing health inequalities is social justice. The Commission on Social Determinants of Health (2008) were unequivocal in their report identifying that where health inequalities can be judged to be avoidable then this is “quite simply unfair”, and further that “social injustice is killing people on a grand scale” (p. Executive Summary). However, in convening the Commission on Social Determinants of Health, the WHO “signalled its desire to do things differently” (Commission on Social Determinants of Health, 2008, p. 28). The Commission further went on to report that its Member States were “increasingly calling for a new model of health – from the point of view of both social justice and increasingly unsustainable reliance on the traditional health-care model” (2008, p. 28).

The contribution of nursing to reducing inequalities and improving health has been stated as forming “the backbone of primary healthcare services worldwide” (WHO, 2009, p. 9). In June 2015, Margaret Chan, Director-General of the WHO, addressed the International Council of Nurses’ conference in Seoul reinforcing nursing’s commitment to a social justice agenda and universal health coverage for all (Chan, 2015). She emphasised the central role of nursing in primary health care and the necessity for nursing leadership at all levels of healthcare. Further, she reaffirmed the Institute of Medicine’s (2011) conclusion that “regulatory and institutional obstacles, including limits on nurses’ scope of practice, should be removed so that health systems can reap the full benefit of their training, skills, and knowledge” (Chan, 2015).

Thomas Huddle (2013), a Professor of Medicine at the University of Alabama in Ohio, identified that the medical profession is far from embracing a social justice perspective where they are socially responsible and advocating for the disadvantaged in their communities. Only in 2014 did the NZMA add a new section to their code of ethics entitled *Doctors in a Just and Caring Society* (New Zealand Medical Association, 2014, p. 12). Nurse practitioners, on the other hand, already work within a social justice framework, and have the opportunity to combine a nursing model of care, identifying and addressing health inequalities, along with utilising their biomedical knowledge to promote the health of individuals, whānau and communities (Browne & Tarlier, 2008; Carryer & Adams, 2017; Kooienga & Carryer, 2015).

However, while WHO principles focus on social justice and reducing health inequalities, the introduction of neoliberal health policies have created the illusion of achieving these, within the framework of improving efficiencies, reducing health care costs, and increasing consumer engagement. There is now growing concern that neoliberalism is further disenfranchising marginalized populations, increasing health inequalities, and the burden of long term conditions (Camargo Plazas et al., 2012; Coburn, 2000; Peacock et al., 2014; Racine, 2009; Yanicki et al., 2015). Indeed, neoliberalism has been described as being “bad for our health” (Mooney, 2012).

In New Zealand, the health reforms of the 1990s included the introduction of New Public Management policies that were market-oriented, created competition between providers, and introduced general managers (Carryer, Diers, McCloskey, & Wilson, 2010; Gauld, 2009). These neoliberalising reforms were described as the most radical of any across the world (Davis & Ashton, 2001; Peet, 2012). Then in 2001, the Primary Health Care Strategy (A. King, 2001) introduced PHOs, placing greater accountability on general practices to report on health outcomes. District health boards became service providers for secondary services and their hospitals, but retained the decision-making/purchasing split in primary health

care. This resulted in prioritising hospital services to the detriment of primary health care and community services (Cumming, 2015). Little guidance on implementation was provided resulting in a further fragmented health system.

While the potential for the development of nursing was not realised as expected through the Primary Health Care Strategy (Finlayson et al., 2009), the introduction of managerialism, consumerism, and competition threatened the status of doctors (Bleakley, 2013; Gauld, 2009; Lipworth et al., 2013). The work of general practitioners changed, through the use of clinical guidelines, performance targets, health structures, and funding arrangements (Cheraghi-Sohi & Calnan, 2013; Gauld, 2009; Imison & Naylor, 2010). They experienced ongoing difficulties referring to hospital specialists (GP fax Poll, 2015). The NPs and NP candidates were perhaps also caught up in a time of tension for general practitioners, where the general practitioners' dominance in health service provision was being challenged.

A further and potentially concerning consequence of the neoliberal policies for primary health care, has been a considerable shift in the organisation of general practices, from single practices to commercial shareholding organisations of multiple practices. While general practitioner owned businesses operate to create a profit, in essence their income, the new commercial organisations are operating within a business-profit agenda. This model is not dissimilar to the globalisation that is being witnessed in the provision of aged health care facilities by multi-national companies. For example, Green Cross Health originated in the pharmacy industry in New Zealand. In 2014, this group acquired Peak Primary, and are re-branding all practices to "The Doctors". Their objective is to continue to grow patient numbers through the acquisition of other practices and "provide the business with sustainable profit growth and new avenues for funding" (Green Cross Health, 2016, p. 19). This discourse is totally antithetical to a social justice discourse.

## **Reflections on institutional ethnography: Learnings and limitations**

Institutional ethnography, developed by Dorothy Smith, is an empirical, feminist, qualitative method of inquiry to explore the connections between the actions and experiences of people in their local setting and how their social world is textually organised and ruled. In this IE, I began from the standpoint of the primary informants, the NP candidates and NPs working in rural primary health care. From there, I used a mapping technique to explore connections and explicate how the institutional ruling relations are coordinating their activities and experiences in their local setting.

I found using an institutional ethnographic approach to be challenging and insightful, and fully applicable to the research questions I had on entering the study. Indeed, I have become completely hooked by the approach, both in terms of using it as an approach to inquiry, but also as a reflective tool to contemplate and analyse the social world in which I live. The publication on the ethics review process (Adams & Carryer, 2017) demonstrated the use of observing how our social world is textually mediated. Prior to my “discovery” of IE, I had considered using a Foucauldian approach to critically consider the relationships between the individual and the ruling apparatuses of control. Institutional ethnography moved my thinking to explore how our social world and experiences were coordinated in reality, and at times controlled textually.

Further, IE provided a way of explaining how we engage with the ruling relations in the materiality of our own local settings, enacting texts. In the process of enactment, we hold a dialogue, or a text-reader conversation (Smith, 2006a). It is in this moment that the opportunity for change can occur. We can choose, at that point, to enact the texts, to reject the texts, or in some way to adapt those texts, in turn beginning to re-write the ruling relations. Even if we have no option but to enact the texts, by reflecting on how this process is being organised by the ruling relations can provide us with insight. Many texts are taken

for granted, or obscured from view, and many of these texts pose no problem to us in our social world. It is only when our reality becomes at odds with the ruling of our society, that by paying attention to the disjuncture provides us with an opportunity for at least understanding and revealing the texts, and potentially how we enact those texts.

In my study I used the analytical process of mapping. To begin, I developed a scaffold map of the institutional process of becoming a NP as described in authoritative texts by, in the main, the Nursing Council. Clune (2011) had used the scaffold map to good effect in her doctoral research. This provided a framework on which to further describe the primary informants' experiences, demonstrating the extent of text-based work processes through the journey. I found I developed three techniques for achieving this. Firstly, I analysed maps depicting the nurses' journeys over a longer period, identifying key texts and discourses that were being enacted in the local setting. Secondly, I used specific examples tracing text-work-text sequences to show the extent of additional work NPs sometimes undertook. Thirdly, I endeavoured to capture a range of texts entering the local setting, highlighting competing texts and discourses. Through these techniques I was able to show the work NP candidates and NPs actually did through their journeys, how the texts circulating in the environment shaped their experiences, and how institutionally, their work and the development of the NP workforce was being organised and controlled.

I used what DeVault and McCoy (2012) called the "classic" approach beginning from the standpoint of the people and exploring up and into the ruling relations, as is shown in Smith's "small hero" figure earlier in the chapter. However, I pursued several lines of inquiry, rather than perhaps focusing on a single identified problematic. From the outset of the study I was keen to explore the whole journey from RN to NP. I wanted to describe the extraordinary efforts that RNs undertook to become a NP, and then to work in practice delivering NP services. I hope I have done at least some justice to these truly courageous women.

Further I had a sense that there was considerable complexity in the ruling relations. While there have been suggestions that general practitioner-led primary care is the main problem, I was certain there was more to this story. My analysis showed that there were multiple texts entering into the local environment. The ruling relations were a swirling web of complexity. The rapidity with which the textual relations changed will be little surprise to those of us working in the health sector in New Zealand. New texts, slightly changed texts, and the changing power assigned to texts, resulted in a highly complex, reactive environment. NPs were being subjected to these ever-changing texts in their position at the bottom of the institutional hierarchy, while they were endeavouring to pursue their work as, or to be, a NP.

Institutionally, there were various powerful discourses that continued to compete, creating certain subjectivities and consciousnesses for the primary informants. Historical discourses of both medicine and nursing, neoliberalism, social justice, biomedicine were strongly evident in the local setting. While primary informants in an IE are considered the knowers and experts of their experiences in the local setting, it was very clear to me that the informants had good institutional knowledge. As one NP stated: "You have to be politically savvy". As experienced nurses and wise women, they were able to describe their bifurcated knowledge, particularly in relation to social justice and the conflict with the biomedical model. There were however, many occasions where the texts controlling their experiences were unknown, and there were many that I did not uncover in my inquiry.

What did perhaps surprise me was some of those about turns in decisions, particularly relating to whether to support a NP or not. The fragmented and changing health care sector seemed to drive some of these decisions, whereas in other cases I too remained bewildered. How is it that a DHB who used sixteen locums in a rural area was not prepared to employ the rural nurse as a NP when she was authorised? What was evident in my inquiry was the power that certain individuals hold throughout organisations, whether as managers of local

health providers, or in powerful institutional positions in the Ministry of Health. The ability of people to act without consensus, without seeking the relevant evidence, and without focusing on whose interests are being served was surprising. That the ruling relations have been developed that permit this seemingly random and self-centred behaviour is worrying in our health system. The result is that energy and money is diverted away from other carefully constructed programmes of work, such as the development of the NP workforce.

On the other hand, it was evident that NPs, nurse leaders, general practitioners, and practice managers who were informants in my study, were able to take the texts that supported the NP workforce and run with those. Such texts were given power within the local organisation and enabled the enactment of texts to support the NPs' development. In turn texts were written that became authoritative within the local organisation, and indeed have enacted the rewriting of texts at a DHB level. A particular learning moment for me was when I was trying very hard to identify the texts that might enter into a general practice that were negative to NP development. The general practitioner "did not know of any" and could not help me on that. He was actively choosing to enact texts that supported the development of the NP workforce, and to ignore those negative texts. This is the opportunity that IE brings to us, giving us direction on the ability to change, and allowing us to choose the texts we enact and how we might do this.

There are various limitations to this study. Using IE, I explored a small corner of the social world of how nurses become NPs and then implemented and delivered services. I chose to pursue various lines of inquiry to identify the texts and discourses at work in the ruling relations. This perhaps broadened my inquiry to the detriment of a greater depth of analysis around particular aspects. For example, I did not discover the actual texts resulting in organisations changing their positions on NPs. On the other hand, in the breadth of my inquiry I found the complexity and multiple discourses entering and competing in the local environment, but again, some of these were not pursued to the length that they perhaps

deserved. While I engaged with some secondary informants, I could have undertaken more interviews with those people with institutional knowledge. However, through my textual inquiry, I was beginning to see the complexity and multiple texts, including of contracts themselves that were competing in the local environment. There were many points that I could have focused on one of these areas and undertaken a highly detailed textual analysis.

Rigour and trustworthiness are important components of qualitative research. There is no doubt that this inquiry sits within a contentious field, and I would expect, given my textual exploration, that if this research is afforded any interest from the medical professional organisations, it will be at some point severely criticised. However, I believe I have remained true to the stories of the NP candidates and the NPs, and throughout the analysis I have endeavoured to hold the connection between their standpoint and the institutional layers. Throughout this study I have referred extensively to literature. While I have drawn some of my own conclusions, and certainly have presented a viewpoint that unashamedly supports the development of the NP workforce, I have used evidence to support my rationale wherever possible. Through this, and ongoing communication with NPs, I hope I have demonstrated adequate rigour of the process.

## **Concluding remarks**

This study has explored the ruling relations that are organising and controlling the development of the NP workforce within the rural health care sector in New Zealand. There are multiple texts that may be conflicting in purpose and enacted variably in local situations. Fragmentation of the health sector, the ongoing power of the medical profession, and a persistence in health policy to retain the general practitioner-led model of care creates a complex and often contradictory environment for nurses to become NPs and to deliver NP services in their local rural populations. Yet the number of NPs is continuing to grow, and

increasingly more are choosing to work in primary health care settings, despite the challenges of the ruling relations.

The framework governing the training, education, and practice of NPs while grounded in international experience and evidence, reflects the New Zealand environment and incorporates the bicultural governance of the country through the Treaty of Waitangi. Central to NP practice is the requirement to provide equitable primary health care services to communities and to reduce health inequalities. Marginalised, indigenous, and rural communities continue to be underserved and experience poorer health outcomes. For the NPs in this study, serving their communities and working within a social justice paradigm was evident. Yet despite the potential that NPs offer to meet rural health needs, as a workforce they are seemingly invisible to national policy-makers and health planners.

Without a single overarching process governing the implementation of NPs in New Zealand at a national level, the ad hoc approach to the development of the NP workforce is likely to continue. However, as with other innovations, success breeds success, and there are increasingly more NPs in working collegially in rural primary health care teams alongside general practitioners and other members of the health care team. It is in these local practice settings where NPs can actualise their years of practice and education to deliver comprehensive health services to their local communities.

## **Future directions**

The nursing workforce has been identified internationally and in New Zealand as being critical for providing health needs in the future, including the ongoing need for nurses to expand their scope of practice and work at an advanced level. Nurse practitioners not only work at a level equivalent to general practitioners, but also work traversing the boundaries between biomedical practice and nursing within a social justice paradigm (Browne &

Tarlier, 2008). There is a great need for research to explore the work that NPs do that adds value to the biomedical model, meeting the health needs of those who are indigenous, marginalised and have reduced access to health care (Carryer & Adams, 2017). Particularly, there is a need to explore how NPs work with Māori and their whānau, using models of health that reflect the health and wellbeing of Māori.

Arising from the data in this study was a disjuncture expressed around scopes of practice. While RNs and NPs were expected to work at the top of their scope of practice the same did not apply to general practitioners, and the primary informants raised that general practitioners might often retain less challenging work rather than give this up to either a NP or a RN. There is a need to undertake research in New Zealand to explore how the work of general practitioners can be organised within a team including NPs to ensure both are effectively working and utilising their full scope of practice, and meeting the health needs of their communities.

While data is collected by the Nursing Council and by the New Zealand Nurse Practitioners' (NPNZ) biennial survey, there is a need to have a more complete data set on the NP workforce, the work they are undertaking and issues they are facing. From the NPNZ survey (D. Williams, 2016) there were approximately one third of NPs who identified as only partially working to the NP scope of practice. For New Zealand to be benefitting from this highly skilled workforce, greater understanding is needed of the employment structures and actual work practices of NPs in primary health care, including rural areas (Carryer & Adams, 2017). Here, there is a need to analyse the variety of business models in which NPs are employed.

Finally, data from this study showed how policy changes can occur rapidly, having consequences for other programmes of work and projects, such as the physician assistant pilot. The New Zealand NP project has lacked an overarching strategy and ownership for the implementation of the NP workforce across the country. The development of a Ministry

of Health text to govern the process of implementation, with clearly established outcomes and accountabilities, would coordinate the development of NPs in local settings. Further, by having such a boss text (Smith, 2006a) in the ruling relations, would result in a series of text-based work processes that would be enacted through the health sector. While changes to policy can still result, such a text would serve to protect the ongoing establishment of the NP workforce, and in turn promote access to comprehensive primary health care services to those marginalised, rural, and Māori communities.

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# Appendices

## APPENDIX A: Publication – Adams, Carryer & Wilkinson (2015)

Adams, S., Carryer, J., & Wilkinson, J. (2015). Institutional ethnography: An emerging approach for health and nursing research. *Nursing Praxis in New Zealand*, 31(1), 18-26. doi: <http://www.nursingpraxis.org/311-institutional-ethnography-an-emerging-approach-for-health-and-nursing-research.html>

DRC 16



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### STATEMENT OF CONTRIBUTION TO DOCTORAL THESIS CONTAINING PUBLICATIONS

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of Candidate: Sue Adams

Name/Title of Principal Supervisor: Prof Jenny Carryer

**Name of Published Research Output and full reference:**

Adams, S., Carryer, J., & Wilkinson, J. (2015). Institutional ethnography: An emerging approach for health and nursing research. *Nursing Praxis in New Zealand*, 31(1), 18-26. doi: <http://www.nursingpraxis.org/311-institutional-ethnography-an-emerging-approach-for-health-and-nursing-research.html>

In which Chapter is the Published Work: Relates to chapter 3

Please indicate either:

- The percentage of the Published Work that was contributed by the candidate: and / or
- Describe the contribution that the candidate has made to the Published Work:

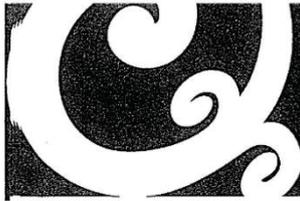
The article was fully drafted by the candidate. Supervisors Prof Jenny Carryer and Dr Jill Wilkinson made editing recommendations to the final draft.

Sue Adams  
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Candidate's Signature

28 Aug 2017  
Date

Jenny Carryer  
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Principal Supervisor's signature

30 Aug 2017  
Date



## INSTITUTIONAL ETHNOGRAPHY: AN EMERGING APPROACH FOR HEALTH AND NURSING RESEARCH

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### Abstract

This article introduces institutional ethnography as a valuable approach to sociological inquiry for health and nursing research in New Zealand. Institutional ethnography has gained increasing prominence across the world because of the potential transformative nature of the research. Institutional ethnography explores how everyday activities and experiences are coordinated by the ruling relations and their institutional processes and discourses. By mapping how our everyday lives are textually organised, the ruling relations are made explicit. This article provides an overview of institutional ethnography, introducing key concepts. Research particularly relevant to health and nursing will be referred to as a way of showing the value of institutional ethnography to nurse researchers. The paper concludes by describing how institutional ethnography is being used in research on establishing nurse practitioners and their services in rural primary health care.

### Keywords

Institutional ethnography; ruling relations; nurse practitioners; health research; sociological inquiry

### Introduction

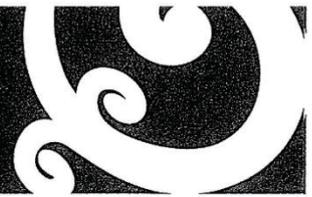
Institutional ethnography (IE) is a critical form of social inquiry founded by Dorothy Smith. Institutional ethnography can be described as a “Marxist-feminist, reflexive-materialist, qualitative method of inquiry” (Hussey, 2012, p. 2). Since Smith’s early writings during the 1970s, IE has continued to be shaped and developed by Smith along with a growing group of well-respected researchers and theorists from North America and, increasingly, other parts of the world. Institutional ethnography publications listed on Scopus have more than doubled for each five year period from 1990, to a total of 184 in August, 2014. Institutional ethnography is now being used across a wide diversity of disciplines, including health, social work, law and justice, and education, because of its relevance to exploring and making visible the relationship between

the everyday activities and experiences of people, and the institutional construction of the social world. The term institutional ethnography explicitly connects an emphasis on the structures of power – institutions – with the everyday practices and experiences of people at the local level – ethnography (Appelrouth & Edles, 2011).

This paper introduces IE as a valuable research approach for health and nursing in New Zealand and adds to previous articles on methodology published in this journal. The theoretical underpinnings of IE as

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Adams, S., Carryer, J., & Wilkinson, J. (2015). Institutional ethnography: An emerging approach for health and nursing research. *Nursing Praxis in New Zealand*, 31(1), 18-26.



an alternative sociology, and the key concepts of the ruling relations and experiential knowledge in the everyday world are described. Finally, a brief overview is provided of how IE is being used for research on nurse practitioners in rural primary health care.

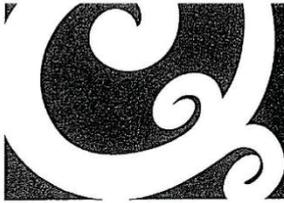
Dorothy Smith (b. 1926), a Canadian sociologist and feminist activist, began her work developing an alternative sociology during the second-wave of the contemporary women's movement in the 1960s and 1970s. She has been described as "a world-renowned Marxist feminist scholar and activist and a formidable intellect" (Carroll, 2010, p. 9). Her work in founding IE stemmed from what Smith described as the disjuncture she experienced early in her career between being a sociologist in a male dominated and gendered institution, and a single mother of two young children (Smith, 2005). She objected to the ways that traditional positivist sociology categorised people into designated groups, including housewives and single mothers, and then sought to explain their activities, behaviours, or their culture. She believed that this generated ideology not knowledge, and served further to perpetuate oppression and discrimination, particularly for women (Smith, 1974, 1990a). She identified that her own experience and knowledge of her everyday life was disconnected from the official or authoritative representations of her world and work as a sociologist (Bisaillon, 2012). However, as her work progressed Smith updated her terminology from a sociology for women to that of a sociology for people clearly signalling that we must begin our understanding of the social world from the experiences or standpoint of people as they go about their everyday lives (Smith, 2005).

Today, Dorothy Smith still holds a position as professor emerita at the University of Toronto, as well as adjunct professor at the University of Victoria, British Columbia, where she continues to develop IE with scholars and students from across the world.

### **Institutional ethnography: An alternative sociology**

Institutional ethnography is an alternative sociology. It describes how the social world is (ontology), the knowledge required to understand our social world (epistemology), and how we go about collecting that knowledge (methodology). The key premise of IE is that our social world, and our everyday activities in it, are controlled and coordinated textually and discursively by the institutional or ruling relations of our society. The web of ruling relations is produced by the ruling apparatuses that are "those institutions of administration, management, and professional authority, and of intellectual and cultural discourses, which organise, regulate, lead and direct contemporary capitalist societies" (Smith, 1990b, p. 2). Organisation and coordination of society, or of our social world, is achieved textually. Texts may be written, oral or visual, and are replicated across time and place, appearing in many different places and locations simultaneously. People are connected through texts from their local setting to others in similar local settings but outside of their interactional world (Bisaillon, 2012). For example, how a person with diabetes navigates the health system, how a nurse prepares a patient for surgery, and how a victim of domestic violence accesses services. It is the texts actively entering into our everyday activities that result in such similar experiences. Mostly, these texts are unknown to us and taken-for-granted.

Informants or participants in the research are knowledgeable subjects, and it is from this starting point that researchers in IE begin to discover how people's everyday activities and experiences are textually coordinated by the ruling relations. Power imbalances, tensions, and contradictions are the entry points to exploring how their social world has been organised by society's structures, which is of particular value for nursing. Nurses working in clinical settings, are subjected to organisational and institutional processes created from dominant ideologies, such as biomedicine,



health care management, and the regulation of professions. The nurses' work is controlled by these systems, and yet they often experience tensions and contradictions between what they are required to do, and what they believe is the right thing to do for that particular patient in that particular context (McGibbon & Peter, 2008; McGibbon, Peter, & Gallop, 2010).

Using data collection methods, such as interviews and observations, the researcher opens the door to exploring how the institutional processes, or ruling relations, shape those experiences (Deveau, 2008). The analytic focus and key endpoint of IE is on understanding how society's institutions govern people's lives, explicating how their lives are socially coordinated (Walby, 2007). The exposure of the ruling or institutional relations brings into consciousness possibilities for change and transformation, showing the people, informants and researchers ways of achieving change. Political activist ethnography has emerged from IE as a more radical approach where ruling regimes are that individuals and researchers explicitly and actively want to change identified (Hussey, 2012). Such researchers are often engaged in political and human rights movements.

### **Key concepts in institutional ethnography**

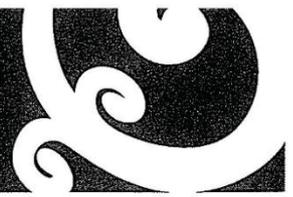
Marie Campbell, an eminent institutional ethnographer and nurse, discusses how to "think" as an institutional ethnographer, identifying the importance attached to "understanding the social world that is enacted in institutions" (Campbell, 2010, p. 497). She says that meanings are never fixed, which relates both to the definitions of terms in IE, and the social world itself as we are exploring it. In many ways this premise has led to the ongoing evolution of IE, as researchers work with, and make sense of, the key concepts in their world of research.

The caveat for this section of the article is that IE is a way of exploring the social world that is dynamic

and reflexive. While endeavouring to introduce the reader to the key concepts of IE, it is imperative that these concepts themselves should not become a part of the ruling relations that coordinate the work of researchers and could defeat the purpose of IE. Bisailon (2012) explains that "[t]hrough proximity and personal investment, we might ... neglect to interrogate and challenge the very language, concepts, notions, and ideas that we are accustomed to using" (p. 614). Hence as the key concepts are described, the reader's attention will be drawn to publications on IE, and reveal a little of how these concepts are used to inform the IE researcher, particularly in the field of health and nursing research. The key concepts of IE are explored further under two broader theoretical concepts the ruling relations, and experiential knowledge in the everyday world.

### **The ruling relations**

Social relations are located in people's interactional activities, the activities that we do in our everyday lives, and, Smith (2006b) says, we participate in those social relations without knowing what we are doing. The ruling relations or institutional relations are a part of the social relations. They are the "complex of objectified social relations that organise and regulate our lives in contemporary society" (Smith, 1999, p. 74). McCoy (2006) explains: "You get out of bed, turn on the tap, make coffee, read the newspaper you collected from your front step – and you are participating in institutional relations (municipal water systems, international trade, the mass media)" (p. 111). Here, your social world is being coordinated and organised by those ruling relations. These ruling relations are textually mediated through print, film, TV, internet, mass media, and so on. In other words, the ruling relations enter into the local social setting by texts, which may be written, oral or visual. These texts are produced from governments, agencies, corporations, organisations, industry, educational and research establishments, professional bodies, the media,



cultural and religious groups, and have the ability to reach many people. Such texts are both standardising and replicable. A “web of relations” is created through which ruling is achieved (Bisaillon, 2012, p. 618) and results in people from across different areas but in similar local settings experiencing the social world in similar ways.

As we go about our everyday activities, we activate the texts that coordinate our social world, and we are ‘hooked up’ into the relations of ruling, usually subconsciously in a way that we take-for-granted our activities and experiences (Smith, 1999). In turn the ruling relations are perpetuated and may be strengthened further. Chubin (2014) wrote an autoethnography as a woman in Iran experiencing sexual harassment, and using IE described the institutional processes that create and sustain the silence of women. She stated “[w]omen’s silence ... both originates from and sustains patriarchal institutional processes” (p. 184). By continuing to participate in the web of ruling relations, through their silence in this instance, the women are seemingly affirming the ideologies and work of the institutional powers.

The knowledge that is held by the ruling relations is objectified knowledge – it is the official or authoritative knowledge of our social world. There is an emerging body of nursing research from North America using IE to explore how the authoritative knowledge is incorporated into institutional processes to strongly control and organise the work of nurses in the clinical setting (Folkmann & Rankin, 2010; Hamilton & Campbell, 2011; McGibbon & Peter, 2008; Rankin, 2009). The researchers identify points of tension, contradiction or disjuncture, which the nurses experience as their nursing knowledge and everyday experience is in contrast to regulation and control applied to their work. Authoritative knowledge may be incorporated into legislation, professional regulation,

policy, strategy, practice guidelines, contracts and so on. The researchers are not arguing that authoritative knowledge is a bad thing, what they are primarily concerned about is that nurses’ knowledge from their experience is not acknowledged, often invisible, and not utilised in the creation of new knowledge.

Research by Hamilton and Campbell (2011) investigated nursing productivity, workload and staffing in three Texas hospitals, in the context of recent hospital reform. The hospitals used sophisticated software packages to collect data and calculate staffing levels for optimum productivity. The texts, in this case the software packages, are the way that the authoritative knowledge is used in the local situation to control the activities and actions of the nurses. The researchers found the assumed dominance of institutional and managerial knowledge, applied through software, subordinated what nurses know. The day to day experiential knowledge of the nurses was not taken into account nor used to inform the processes. The power that plays out between texts is known as intertextual hierarchy (Smith, 2005). Certain texts more powerfully organise what happens in the locality than others. For example, in a residential care setting for women with mental illness, the regulatory texts about patient safety took precedence over diabetes guidelines with the recommended exercise requirements (Lowndes, Angus, & Peter, 2013). In other words, people generally activate the more powerful texts. These regulatory, or boss texts, are created and authorised through institutional processes, instructing people on what to do, how to act, or how to carry out specific practices (Bisaillon, 2012).

### **Experiential knowledge in the everyday world**

People’s lived experiences and ways of knowing the world are often in contrast to ideological or conceptual ways of knowing about something (Smith, 2005). The experiential knowledge of people in their social world



is central to IE - the actualities of everyday activities and experiences – what people do, and sometimes don't do, and how they go about doing things. Smith talks about 'doings' and 'happenings' and distinguishes experience in IE from the phenomenological idea of experience (Smith, 1999). In IE, experience is used as a way to explore how one person's local world, or locality, is connected to others working and living in similar situations but in different places. So experience from the standpoint of people in that locality is used to provide clues and information about how people's lives are coordinated and organised within society (Bisaillon, 2012).

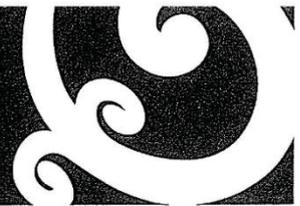
Experiential knowledge is embodied knowledge. It is the taken-for-granted tacit knowledge of the people in a particular setting. Folkmann and Rankin (2010) explored the medication work of nurses in hospitals and identified that the embodied knowledge of the nurses was at odds with the objectified or authoritative knowledge that created the institutional processes for medication procedures in hospitals. Starting their research from the standpoint of the nurses, Folkmann and Rankin found that nurses' medication work did not progress in a linear and standardised way as was expected by the regulatory controls and institutional processes that were in place, but was characterised by "complexity, interruption and ambiguity" (p. 3224). The intent of the technologies and procedures was to improve patient safety, but their coordinating power did not acknowledge nurses' knowledge around the complexity of the situation. The lack of inclusion of the nurses' knowledge was a significantly missed opportunity in reforming processes and procedures for the ordering, dispensing and administering of medications. Inadvertently, patient safety is at risk.

A tension or contradiction that exists between the authoritative knowledge and embodied knowledge is called a disjuncture. People experience this as living in two worlds, which Smith called the bifurcation of

consciousness (Smith, 2005). For nurses, they often experience the disjuncture between their professional experiential knowledge, and that of the authoritative or official knowledge imposed on them through the ruling relations. However, nurses have been so strongly conditioned to perceive the world from the perspective of the institution or ruling relations that they continue to engage with and perpetuate the institutional processes (Rankin & Campbell, 2009).

Disjuncture is often experienced as a tension or frustration, or even stress and distress. However, how a person's experience has been textually mediated through institutional processes is often beyond awareness. Rankin and Campbell (2009) explored how health information technology and health services research has generated objectified, authoritative knowledge that is being used to reform the health care system with the promise of ongoing improvements. From observing and talking with nurses they found "[a]t each turn of nursing activity the nurses relied on knowledge from a care pathway – as opposed to relying on what they know as knowledgeable actors, embodied and embedded in a professional domain" (Rankin & Campbell, 2009, p. 15). The nurses talked about how their nursing work 'chafed'. They experienced the tension of living in two worlds – one, their embodied world of knowing about nursing and how to do it, and two, the other world of research-based and standardised knowledge applied to a whole patient group through care pathways. Similarly, IE research in paediatric intensive care units identified the often extraordinary distress that the nurses experienced as they endeavoured to make sense of their lived experiences of caring for extremely sick, and often dying children, while their work was being controlled by biotechnologically driven institutional processes (McGibbon & Peter, 2008; McGibbon et al., 2010).

The lived experience of people's actions in their



everyday lives in IE is often termed work. Work may be activities that are a part of paid work, but equally may be our work as parents, carers, service users, members of a community group, voluntary workers, members of clubs and societies, and so on. Work is what takes time, effort and intent in people's everyday lives and is in some way connected by the work of others, using similar resources, and organised by similar information and texts (Smith, 2005). In this sense work is not peculiar to one individual, but it is likely that others elsewhere will be doing similar things and activities.

The concept of work is used in IE to really focus the researcher on what people do and how their activities and experiences are being structured within society by the ruling relations through texts. As examples, Eric Mykhalovskiy (2008) explored the everyday 'healthwork' of poor, socially marginalised people living with HIV. He identified the disjunctures these people experienced between their lived experiences and the conceptual and rational biomedical decision. Mykhalovskiy explored the healthwork of people with HIV in their navigation of health services and taking, or not taking, treatments, particularly antiretroviral therapies. In a study in aged care facilities in the United States, Tim Diamond (1992) as a participant observer, used IE to investigate the work that both residents and health care assistants do to accommodate the institutional processes that organise their day to day lives.

A group of nursing researchers investigated the issue of quality and wait times in emergency departments (EDs) from the standpoint of nurses and their work (Melon, White, & Rankin, 2013). They looked at the nurses' work to reach a triage decision, structured by the Canadian Triage and Acuity Scale (CTAS), and the ongoing 'invisible' work between the logging of the numerical score (one to five) and the patient being seen by a physician. These texts had specific intention to demonstrate efficiency and quality, in order to

perhaps satisfy media, public, and governmental concerns. But these texts – both the forms, documents, and management discourse – had an adverse effect on quality where the reduced wait time did not equate to better care. These researchers identified that so-called quality emergency care was a powerful ruling discourse, which inserted into the nurses' work the interests of politics and economics.

### **Applying institutional ethnography in New Zealand: Nurse practitioners and the ruling relations**

The research being undertaken by the first author explores the problem of why in New Zealand (NZ) we have so few nurse practitioners (NPs) in rural primary health care. Internationally, NPs have provided essential primary health care services to indigenous, deprived, rural and mainstream populations. Significant health disparity continues to exist in underserved populations in NZ. Health services in rural areas of NZ are facing serious challenges with an ageing population, reducing medical workforce, and more complex health need. Additionally, the ongoing medicalisation of health and specialism of services is doing little to reduce health inequalities. Nurse Practitioners are a highly trained and economically sound workforce solution (Bauer, 2010; Federal Trade Commission, 2014), available in NZ since 2001. Yet progress to establish NPs as part of mainstream primary health care services in NZ has been extremely slow. Progress has been compounded by policy and legislative issues and a failure to explore the potential from a range of organisations and institutions. In this section, research, which is currently in progress, will be used to overview the research approach and methods.

The entry point for an IE investigation begins in a particular orientation of the researcher's interest and attention (Campbell & Gregor, 2004). It is not necessary for the researcher to remain neutral. The stance for this research is unashamedly in support of



the NP project in NZ and considers how NP services can be increased in rural primary health care. The focus of interest, or the puzzle to be solved, is to make visible how the ruling relations have controlled the NP project.

In IE there are three tasks that are paramount to inquiry: documenting the work that people do in their locality, identifying textually mediated discourses, and mapping social relations (Lowndes et al., 2013). Data collection techniques in IE are largely consistent with those of other qualitative ethnographic approaches, including interview, observation and textual analysis. The research began with the first author interviewing NP candidates, or interns, and NPs about their experiences of becoming a NP and working in practice. However, importantly, the researcher's purpose in an IE is not to "generalise about the group of people interviewed but to find and describe social processes that have generalised effects" (DeVault & McCoy, 2012, p. 383). The focus in the interviews is not on finding recurrent themes, but on identifying the texts that are being activated by the NP candidates and NPs in coordinating their experiences. Each informant provides new information, and each interview builds on the knowledge gained from the previous interview. Data collection and analysis are iterative and inductive processes that begin from the first interview and continue to the final write-up (Bisaillon & Rankin, 2013). Rarely can an IE be planned out in advance – especially in identifying who is going to be interviewed, when and about what. DeVault and McCoy (2012) explain:

*The process of inquiry is rather like grabbing a ball of string, finding a thread, and then pulling it out. Institutional ethnographers know what they want to explain, but they can discover only step by step whom they need to interview or what texts and discourses they need to examine. (p. 383)*

The unravelling of an IE can be a concern for ethics committees who themselves are part of the ruling relations that coordinate research (Truman, 2003), and was a disjuncture the researcher (SA) noticed in the ethics application. The researcher (SA) needed to demonstrate how ethical safety could be ensured (and was absolutely committed to doing this) for the participants, while undertaking an IE to uncover potentially unknown institutional processes of ruling. Ethics for the research was approved by the Massey University Human Ethics Committee (North).

The first author (SA) is now reaching the end of what is often called in IE the phase one of interviews. These are the interviews with participants in the locality, and in addition to NP candidates and NPs, informants have now included general practitioners, practice managers and nurse leaders. Most of these interviews have been conducted individually, but some have been as small groups or talk groups. Institutional ethnography considers informants' stories and descriptions of what they do and have done. The researcher's work is to identify some of the institutional texts, processes and discourses that are shaping the informants' experiences (DeVault & McCoy, 2012). The points of tension and contradiction that can identify a disjuncture between lived embodied experience and institutional reality are particularly important and often only identified during the data collection process. A particular disjuncture may become the focus of the research, known as the problematic, from which the ruling relations can be further explored and exposed.

The next phase of the research is to investigate the institutional processes and discourses at the extra-local level, which may include further specific interviews with individuals from institutions and organisations who are producing the organising texts and discourse. Analysis is ongoing throughout the research process. However, at this stage mapping is introduced as a particular analytical tool in IE. Mapping

is a geographical metaphor used “to explore particular corners or strands within a specific institutional complex, in ways that make visible their points of connection with other sites and courses of action” (DeVault & McCoy, 2012, p. 383). Key to analysis in IE is that there is a course of action that produces a text, and this in turn leads to further action. This is called the “act-text-act sequence” (Smith, 2006a, p. 67). The researcher’s work is to expose which texts and discourses are coordinating NP candidates, NPs, and others, in local practices to establish and implement NP services. Particular interest is paid to the texts that enable or impede particular activities, and the power afforded to those texts by the practitioners themselves. The relationship between texts and action can be mapped, ultimately highlighting opportunities for change.

### Conclusion

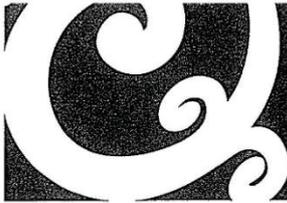
Institutional ethnography is an emerging approach to sociological inquiry. The authors have described how IE is being applied to research on establishing NP services in rural primary health care. Institutional ethnography was considered particularly relevant

because of the ability to expose the ruling relations and institutional processes of power that are controlling the development of NP services. By explicating the ruling relations NPs and their colleagues in primary health care settings will see how their world is being shaped, providing an opportunity for those NPs to interact and engage differently with the institutional processes. It is hoped too that this information will be used by some of the institutions and organisations to review their texts and discourses.

This paper has introduced the reader to IE, and identified ways in which IE as sociological inquiry could be applied in the NZ health context. IE offers a range of possibilities for the NZ researcher. It is an emergent mode of inquiry where researchers will need to adapt, revise, and improvise as IE is used in different applications (DeVault & McCoy, 2012), including to the NZ context. Particularly, IE may have useful applications in NZ addressing inequalities in health; health and service needs of Māori, marginalised and high health needs groups; and the nursing contribution to health service delivery.

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## APPENDIX B: Publication – Carryer & Adams (2017)

Carryer, J., & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian*, 24, 525-531 doi: <http://dx.doi.org/10.1016/j.colegn.2016.12.001>

DRC 16



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### STATEMENT OF CONTRIBUTION TO DOCTORAL THESIS CONTAINING PUBLICATIONS

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of Candidate: Sue Adams

Name/Title of Principal Supervisor: Prof Jenny Carryer

Name of Published Research Output and full reference:

Carryer, J., & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian*, 24, 525-531. doi: <http://dx.doi.org/10.1016/j.colegn.2016.12.001>

In which Chapter is the Published Work: Relates to chapters 1, 2 and 8

Please indicate either:

- The percentage of the Published Work that was contributed by the candidate: \_\_\_\_\_ and / or

- Describe the contribution that the candidate has made to the Published Work:

Prof Jenny Carryer raised the intellectual direction of the paper which was to analyse and interpret some sub sections of data which fell outside the scope and purpose of the actual thesis. The candidate provided data and described the data. Both contributed to the final editing and preparation of the article for publication.

Sue Adams  
2017.08.28 10:24:27 +12'00'

Candidate's Signature

28 Aug 2017

Date

Jenny Carryer  
Digitally signed by Jenny Carryer  
Date: 2017.08.31 12:11:41 +12'00'

Principal Supervisor's signature

31 Aug 2017

Date

GRS Version 3– 16 September 2011



## Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study

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### ABSTRACT

**Objective:** To consider the alignment of the Nurse Practitioner (NP) role in NZ with the goals and aspirations of the many countries facing challenges to maintaining health service delivery and reducing health disparities.

**Methods:** Data was collected as a component of a larger institutional ethnography but for this paper was thematically analysed to answer specific questions about NP practice alignment with a transformative service agenda. Interviews were conducted with NPs and management staff in private general practices, health clinics operated by District Health Boards (DHBs), and not for profit health providers, including Primary Health Organisations (PHOs), and community/indigenous health clinics.

**Results:** The findings demonstrate that NPs have competently taken on a range of previously deemed medical tasks but also practice congruently with a nursing approach to practice. They provide comprehensive person and family centred care, focussing on seamless and integrated service delivery. Because their role is often regarded as only a substitute for medicine they are often employed in ways that limit their full potential.

**Conclusion and implications:** NPs can provide a service that closely replicates the goals of the NZ Health Strategy (2016) and the current aspirations of many countries concerned to provide sustainable health services.

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### 1. Background

There is widespread concern that health systems are under mounting pressure from, amongst other challenges, the epidemic of long-term conditions. It is acknowledged that a range of factors, including lifestyle, genetics, and access to health care contribute to long-term conditions. Overarching this is the recognition that poverty, poor health literacy and marginalisation of any form make a significant contribution to individual health status, the subsequent demand on services, and the high costs to communities and the economy (Browne & Tarlier, 2008; Villeneuve, 2008; World Health Organization, 2014).

Long term conditions, such as cardiovascular disease, diabetes, respiratory disease, mental illness, arthritis and many cancers have become the leading causes of morbidity and premature mortality

across the world (Bauer, Briss, Goodman, & Bowman, 2014; World Health Organization, 2014). Genetics play a role in the development of obesity (Toomath, 2016) and some long term conditions but the increasing incidence and prevalence of these is significantly driven by socio-economic and environmental factors. These include the ageing of populations, the contribution of adverse lifestyle behaviours, and the social, political, economic and cultural contexts in which people live and work and which significantly influence an individual's ability to lead a healthy life.

Despite long standing awareness of the relationship between social class, poverty, ethnicity, marginalisation and poor health outcomes, countries seem largely unable to make significant inroads in challenging this factor (Marmot & Bell, 2012; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Rasanathan, Montesinos, Matheson, Etienne, & Evans, 2011). In New Zealand, it is suggested that health disparities continue to increase (Blakely & Woodward, 2000; Matheson & Loring, 2011; Woodward & Blakely, 2014). A national Primary Health Care Strategy (King, 2001), launched in New Zealand, explicitly recognised the connection between the scope and caliber of primary health care and the opportunities for

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a country to improve community health and reduce acute service demand. There has been long standing historical and international debate as to the need for improved universal and equitable primary health care coverage and services (Kruk, Porignon, Rockers, & Van Lerberghe, 2010; Starfield, 2012). Despite such longstanding debate, the goal of genuine transformation of service delivery remains elusive. As Kooienga and Carryer (2015) argued, medicine is hegemonically accepted for its natural leadership of health services, and:

[A]fter long years of health services framed by the culture of medicine, most countries report an epidemic of chronic disease, a resurgence of infectious diseases related to poverty, huge inequalities in access and outcomes, major expenditures occurring in the last year of life, and often insufficient investment in child and youth health. (p. 806)

Elsewhere it has been argued that long term conditions, once established, require a model of health care delivery that is different from the pervasive biomedical model established to address and treat acute demand (Carryer, Doolan-Noble, Gauld, & Budge, 2014; Commission on Social Determinants of Health, 2008). Local health systems should move away from disease specific services and reorient to provide community primary health care delivered by providers with enhanced capabilities (Friedberg, Hussey, & Schneider, 2010). The need for a fit for purpose workforce that addresses growing health disparities and can respond to increasing levels of long term conditions with responsive models of care now preoccupies many countries in their health sector and workforce deliberations.

In summary, the world is faced with increasing long term conditions, obesity, and ongoing (if not growing) health inequalities of poor, marginalised, indigenous and displaced people (Stephens, Porter, Nettleton, & Willis, 2006; World Health Organization, 2014). The biomedicalisation and pharmaceuticalisation of health and chronic illness, has focused medical research and practice on a 'pill for every ill', resulting in a health care system unable to understand and cope with the increasing complexity of health need (Busfield, 2010; Martin & Peterson, 2009; Williams, Martin, & Gabe, 2011). The World Health Organisation (WHO) recognised that a new model of health care delivery is required to meet the current global health crisis (Commission on Social Determinants of Health, 2008).

In this paper we argue that nurse practitioners (NPs) offer the exact transformation in care that the WHO seeks. We challenge the necessity of continuing to conduct research demonstrating direct comparisons of equivalence between nurse practitioner (NP) and doctor or physician-led care, and in fact argue, using our data, that such questioning has limited the way in which NP services could be envisaged, and limited acknowledgement of their potential points of difference.

## 2. Literature review

The launch of the nurse practitioner (NP) role in New Zealand drew on a long history from the United States of America (USA) and coincided with a relatively simultaneous launch in Canada and Australia. NPs, in NZ as in many other countries, are masters educated, experienced nurses who are legislated to independently provide diagnosis, full management and to prescribe medications and treatment according to their clinical judgment.

Regardless of the focus of NP development elsewhere, in New Zealand and Australia the role was always conceptualised as very much an advancement of nursing services rather than any notion of substitution for medicine (Carryer, Gardner, Dunn, & Gardner, 2007; Carryer & Yarwood, 2015; Kooienga & Carryer, 2015; Matenspeksnijder, Grypdonck, Pool, Meurs, & van Staa, 2014; Quinlan

& Robertson, 2013). Nursing leaders saw the role as holding the potential to transform existing service delivery rather than simply provide expert substitution for the status quo. It is true that in many settings NPs do indeed substitute for medical practitioners in their absence, but this does not alter the potential for them to do more than that.

There is a vast amount of literature now on all aspects of NP development and services. Here we refer only to examples of literature that capture the core themes underpinning our focus in this paper. These themes are substitution, cost comparison, safety and difference. Because of medical dominance (Currie, Lockett, Finn, Martin, & Waring, 2012), decision makers at most levels of the health system tend to think of medical solutions to health problems. It is therefore perhaps inevitable that NPs have mostly been considered as potential substitutes for medical providers or services. This belief system gave rise to a large amount of comparative research that has clearly demonstrated the quality and safety of NP services when compared to services provided by medical practitioners (Dierick-van Daele, Metsemakers, Derckx, Spreeuwenberg, & Vrijhoef, 2009; Horrocks, Anderson, & Salisbury, 2002; Martínez-González et al., 2014; Pirret, Neville, & La Grow, 2015; Stanik-Hutt et al., 2013; Swan, Ferguson, Chang, Larson, & Smaldone, 2015). Such research has undoubtedly been important in establishing that NP services are safe and that the public can be thus assured. It has played an important part in the history of the role development.

Other research has attempted to provide cost comparisons between NPs and physicians (Dierick-van Daele et al., 2010; Donald et al., 2015; Hollinghurst, Horrocks, Anderson, & Salisbury, 2006; Martin-Misener et al., 2015). Such research has shown that NPs are cost effective despite generally spending longer with clients. Cost comparisons are challenging as they are influenced by a range of easy to measure and some more difficult to measure important long term outcomes. In addition, comparative training and preparation costs are generally not sufficiently transparent and thus not easily assessed. However, the American Academy of Family Physicians (2012) identified that it took approximately four years longer to train a family physician compared to a nurse practitioner. Yet despite this, nurse practitioners provide equivalent care and there is no evidence to support the direct value of the longer training.

In a smaller systematic review researchers concluded that advanced practice nurses, including nurse practitioners, provided safe and effective primary care, again finding that nurse-led care was comparable, and for some measures superior to physician-led care (Swan et al., 2015). Further, these researchers identified that the advanced practice nurses in these studies provided care that was "in some ways different" (p. 403) from the care provided by physicians. Levels of patient satisfaction with nurse practitioner care clearly indicated that in some way the care is different. This will come as no surprise to nurse practitioners who work within a model of care where the individual patient's needs are considered within the context of family, community and environment (Budzi, Lurie, Singh, & Hooker, 2010). It is this area of difference that this paper begins to address.

In consideration of this notion of difference, there is a limited amount of literature suggesting that the role of NPs could act as a catalyst for conceptualising different models of care (Bauer, 2010; Carryer & Yarwood, 2015; Chulach & Gagnon, 2016; Kooienga & Carryer, 2015; Wilkinson, 2012). Some studies suggest that NPs excel at relationship oriented and person centred care (Ploeg et al., 2013). Others contend that the NP role is characterised by a useful concern for social justice and a focus for addressing disparities by attending beyond the clinical encounter to the root causes of ill health (Browne & Tarlier, 2008; Xue, Ye, Brewer, & Spetz, 2016).

A substantial body of research has verified that NPs provide safe and effective care within a biomedical model, and that has been a valuable and necessary step in the NP project globally. However,

we believe that it is now time to shift the research to answer a different set of questions. Data from practicing New Zealand NPs suggests that the role has much more to offer than substitution for existing medical approaches to practice and indeed could offer potential for the exact transformation in service delivery that many countries have been seeking.

### 3. Methods

#### 3.1. Setting

The data presented in this paper is a subset of data from a parent study using institutional ethnography to critically examine the establishment of NP services in rural primary health care in New Zealand. The primary purpose of the data collection was to capture the experience of nurses in rural areas who had achieved NP status and subsequent employment. We also included the experience of people in a range of management positions who had engaged with employing NPs. Institutional ethnography is a research approach that enables the exploration of how the daily lives of people (in this study – the NPs) in the local situation are coordinated and organised through texts and discourse produced at the institutional level (Smith, 2005). The research begins from the standpoint of NPs, and throughout the research, their perspective is maintained. The application of institutional ethnography to the parent study has been previously described (Adams, Carryer, & Wilkinson, 2015). Both researchers are academics with a particular interest in the NP role.

#### 3.2. Sample and data collection

Interviews were conducted by SA with a range of nurse practitioners (thirteen) across New Zealand. Their time in practice, as an NP ranged, from one to twelve years and all were women. The area of practice was primary health care in a range of NZ community settings and employment models. All participant NPs worked in areas of high health need in rural locations. Interviews were audiotaped and transcribed (with full consent) and interview length ranged from one hour to one hour 45 min. Transcriptions were returned to each participant for review. A small group interview was conducted with seven other NPs and this group was later used to seek feedback on the findings. Other interviews and observational notes were made in a range of settings involving clinicians and managers (three interviewed) of primary health care settings. Settings included private general practices, health clinics operated by District Health Boards (DHBs), and not-for-profit health providers, including Primary Health Organisations (PHOs), and community/indigenous health clinics. In keeping with the institutional ethnography focus of the parent study the selection of participants was purposive. A wide range of potential participants in appropriate settings were made aware of the study through flyers, word of mouth, and emails.

#### 3.3. Ethics

The main study received ethical approval from the Massey University Human Ethics Committee: Northern, Application 12/062. Full written participant information on the study was provided to each participant, including SA's own personal interest and experience of working to develop the NP workforce in NZ. All participants were given the opportunity to review their transcripts and all consented to the inclusion of their data in the study and subsequent publications.

#### 3.4. Analysis

During the process of data analysis we became intrigued by the degree to which NPs, drawing as they do on a base of nursing education, approached practice differently. The data from transcribed interviews with NPs, observational notes and group interviews was thematically analysed. The transcripts and data analysis process were peer reviewed by research colleagues.

The questions that shaped our analysis were:

- Do nurse practitioners in community settings offer a different type of service from medical practitioners?
- How do nurse practitioners describe their work outside the biomedical diagnostic model?

### 4. Results

“We are part of the profession of nursing. We are not doctors, and nor do we want to be”.

#### 4.1. Comprehensive person and family centered care

NP participants spoke in varied ways about drawing on their background as nurses as a basis for their approach to patients. This involved attention to the widest possible context for the presenting patient including family, community, and social, political and economic factors influencing health. NPs described the value added nature of delivering tasks and procedures previously designated medical, as enabling them simply to provide care to a much wider range of patients. One participant described it thus:

And that's the nurse practitioner's ultimate aspiration, what can I do for you, the patient, and having that knowledge and the tool bag with the tools inside it, clinical, political, management and leadership, all of that encompassing information and knowledge and skill and experience and expertise to be able to deliver a whole package to the patient that's sitting in front of you. [Participant 12]

A participant described the difference she experienced between training medical students and nurse practitioners. She gave an example relating to the diagnosis and treatment of “school sores” [impetigo].

With the NP [trainee] I get them to think about “Are we going to use an oral, a systemic antibiotic, or are we going to use a topical; and is there interaction with any other medication, are there allergies of concern?”... The doctors get that bit, but they have no idea about [the child] going back into a school system, about spread amongst the family, about how the family are living. There might be 10 in the family all living in the same house, extended family, the baby's got impetigo, the grandma's got it but the grandma won't come [into the practice] because it's too much money, and how are they going to afford the medicines, and grandma's got an allergy. You know all of that complexity is absolutely there for the NP. The doctors get the science of it and they understand the disease process beautifully and the diagnostic reasoning is there, but they don't get the other. [Participant 7]

The NP went on to note:

My GP [general practitioner] colleagues they don't always get “why isn't this person better?” Well, this person isn't better because they're going into a social situation that impedes that, that counters the medications. [Participant 7]

Providing comprehensive person and family centered care includes focusing well beyond the presenting problem and addressing the person in their broadest context. Others have already noted the particular listening, and assessing skills of NPs (Budzi et al., 2010) as captured by this respondent:

So what they [patients] do, is they look for someone who will listen, they look for somebody who will take them seriously because in fact what is happening to them is that they are unresolved and the issues in their lives are unresolved... A good example is a lady who came to see me yesterday who has a deep pain in her right leg and she's got some arthritis in her knee and her hip. She's also got some swelling in her toes and she's had a toe amputation, so it's a little bit dicey and I'm thinking okay what's going on. I haven't got the expertise, I don't know what's causing this deep pain. [Previously] I have taken her through an examination and taken a good history. And I'd referred her on to a specialist (she's been back through the system several times), and she's been to see the GP. And I said to her finally, do you want a second opinion... and she said, "No that's not what I'm looking for". She said "No, I've been to the hospital, I've got pain", and she said, "I just want someone to – what am I going to do? I cannot get out of bed in the morning", and she couldn't articulate what it was what she really needed or wanted but I got it and I thought, you want somebody to help you manage the experience that you have with your pain. [Participant 9]

Another NP noted:

I liken my consults to being a little bit like an iceberg – you come in and we're seeing the tip of the iceberg, but within a very short space of time I'm looking below the waterline... So they might have come in with a cough, and I'll do spirometry. I'm challenging them maybe with a bronchodilator, I'll send them for a chest X-ray, I'm diagnosing possibly COPD [chronic obstructive pulmonary disease]. They came in with a cough, next minute I've taken it four steps further... If I look back historically in the notes that person might have been in for a cough three times, and nobody's bothered to say "Why's he got a cough? What's his smoking history? What's his work been like? What are his risk factors and his [occupational] exposures?" [Participant 1]

The consistent finding from research about high patient satisfaction scores with NPs (Budzi et al., 2010; Martínez-González et al., 2014; Swan et al., 2015) often derives from communication styles and the reliable, patient focused and highly contextualised delivery of education.

I've got a particular strength at delivering that at a patient level that other people don't have. So I've got heaps to give, and yeah, it is about patients. [Participant 8]

One NP captured the centrality of nursing succinctly in saying:

At the core the nurse practitioner is a nurse. We come from a nursing background, we recognise the need to build rapport to get honest buy-in from patients and families; and also the recognition of the person and the whānau [family/extended family] as a whole. It isn't even added value, it is core to what a nurse practitioner does. [Participant 2]

In summary NP respondents made it very clear that having acquired the right to order laboratory tests, diagnose, prescribe and other tools, simply meant that they could see more patients in more circumstances. They also consistently emphasised that in holding to their nursing education they approached patient assessment in a highly contextualised manner mindful of the limitations of medical solutions to many presenting problems.

#### 4.2. Seamless care and collaboration

A major part of the discourse accompanying the Primary Health Care Strategy (King, 2001) was the need to move towards more multidisciplinary team approaches and to provide greater integration between sites of service delivery. Better integration of service delivery is also an international goal (Goodwin et al., 2012).

A recent refresh of the Health Strategy in NZ (Ministry of Health, 2016a) emphasises that multidisciplinary teams and integration, alongside a move towards person centred care, remain as pressing goals. Findings in this current research reveal that NPs recognise that patients gain a much better service when their care is genuinely integrated and delivered by a functional multidisciplinary team where each member has the authority to make autonomous decisions. Their approach to patients encapsulates this focus.

Interprofessional teams with shared understanding are known to be more effective (West & Lyubovnikova, 2013). An NP described a collaborative model of care with NP, general practitioner (GP) and nurses for patients who had diabetes:

We've developed our chronic care programme to manage conditions better. We might discuss together [GP and NP] a management plan but I might do all the medication changes... [and] independently decide whether they need to go on insulin. The main aim is that we agree on a target but how we get there is [up to] me. It's around self-management, about the education, about being able to spend more time with those patients... It's whatever that patient needs to self-manage their disease. [Participant 6]

One community based manager in describing an NP noted:

She was working really hard and working across boundaries, through the community, DHB, general practice and for the [indigenous] provider. So that model can work and we've seen that you know, and we've got it working up here. [Manager 1]

And an NP herself noted:

You have to know about the networks that are around you and the services, how to link. You've got to have the relationships. You've got to have good relationships and relationships in key places where it counts. [Participant 2]

This participant described her work within a health provider organisation to develop services to meet the needs of the local disadvantaged and indigenous community:

The amount of work that I have done which has led to other contracts [for services] coming in because of key health issues that have been identified through whānau and communities. It has been because I've been there and working with the community... and addressing needs as they have arisen. And that is a really lovely way of working. We've got so many more people coming through the services that they [the health provider organisation] now want another nurse practitioner. [Participant 2]

And another manager:

A lot of the disparities lie in accessing health within the Māori [New Zealand indigenous population] communities... If you have a NP who is connected with the local community then you actually supply a conduit between accessing health and health status. The country needs to realise how good NPs are and how useful the role is and how beneficial it is to health services and especially to people in low socio-economic groups, the health issues around poverty and everything they've got going on. They need to know that the NP, especially with prescribing, is invaluable in those areas. They whinge on that they've

got no bloody doctors, they whinge on about this disparity in health, and they've got the ability to address it with the NP role. [Manager 2]

An NP reflecting on her way of working noted that:

It doesn't matter what community I'm in now; I can move communities . . . but the focus is still the same. It's still about people and patients and trying to get them a good service, you know? And improving that service and making sure that we do a good job, and that the nurses that are the team around you are doing a good job as well. [Participant 13]

Achieving patient or person centred care required a level of connected pragmatism. NPs focused on making the system work for patients and of considering the patient journey as a continuum and an ongoing event rather than isolated encounter:

I think that that's where we get really good at thinking "Okay, how do I make this happen?" That's the relationship, about getting the patient to where they need to be. [Participant 12]

I think general practice – if we're thinking about looking after a person holistically, having the extensions such as WINZ [Work and Income, NZ], housing corporations, // these are the things that matter to people, and also unfortunately justice. What we need is a one stop wellness shop – but that is bigger picture. [Participant 11]

These participants make it profoundly clear that person centred care goes way beyond what happens in the clinical encounter and involves a thoughtful wrap around and intelligent engagement of the full range of potential services.

#### 4.3. The freedom to actualise the full potential of the role

NPs can only deliver the full transformative potential of the role if the manner of their employment makes this possible rather than constraining their practice. We noted that the impetus of NPs towards transformative care was often impeded by funding patterns or management decisions which gave primacy to medical solutions to presenting problems rather than person centred wellness focused care. One NP noted:

I wanted to set up a women's drop-in centre in one of the rural areas because they have a lot of family violence and rape. They get pregnant because they can't afford the \$10 fuel to get into town to get any contraception, they can't afford a prescription anyway. So they just keep getting pregnant and then they've got all these kids. They can't say no to the partner, because they'll get beaten up. So there's nowhere to go, nothing to do . . . except get pregnant and have kids. It's not that they want to have all these kids, it's that they haven't got any alternative. And what I wanted to do was set up a drop-in place where women could come, have a cup of tea, cup of coffee, listen to music, have a chat, get some contraception, get some health screening, get some STI screening, get their kids immunised, make a cake, you know, it was going to be a 'women's place' not a women's refuge, but a drop-in place. [Participant 2]

Here the NP has assessed her community and devised a service that is contextual, centred on the needs of local women and utilises her ability to provide comprehensive person and family centred care to these clients including prescribing as needed. The solution and proposal was evidence-based and adapted to meet the needs and fit the resources within the local community. A change of manager at the health provider resulted in this project being "completely quashed" with no consideration for the very far-reaching outcomes inherent in such a service.

A number of NPs spoke of the artificial boundaries placed around their services often inherent in the beliefs and expectations of others and sometimes sheer ignorance of the full capacity of the NP role. Many of these NPs are pioneers and their discourse indicates their pragmatism and determination:

But there is also an awareness of the walls you are going to hit as you try and change systems and processes, and sometimes you have to make those changes by leading by example, and by doing so you can manage what you take on board better. And sometimes you do that by negotiation, but sometimes you do that by just getting on and changing the systems and processes. [Participant 13]

## 5. Conclusions and implications for public health

NPs interviewed for this study have clearly articulated their allegiance to a nursing philosophy of practice which informs their attention to presenting health and medical problems. They make clear that their added skills extend their availability to a wider range of patients and in more situations, but they remain attentive to a highly contextualised and wellness oriented approach. Participants are clear that they did not become NPs in order to be more like or substitute for medical practitioners. By drawing on nursing as their basis for a practice approach they see the patient or person as part of a broad context embracing the socio cultural and political in which every encounter demands a unique response.

Further, the participants described how they worked within their communities to develop and shape services to meet the health need of their local populations. Improving access and reducing inequalities in health were central to their understanding of the core role of a NP. Participants recognised the necessary input of the full range of services and of the value for an intersectoral approach which connects health, social care and education. But they also may feel constrained by the expectations imposed by funding or employment structures.

The central focus of this paper was outlined by Browne and Tarlier (2008) when they noted:

NPs must demonstrate practice that reaches beyond a physician replacement function. As politicians and policy-makers call on NPs to resuscitate an overburdened healthcare system that is increasingly affected by neoliberal policies and agenda, NPs must aim to provide primary care in ways that mitigate the impact of health and healthcare inequities using critical social justice approaches. (p. 88)

This statement was made eight years ago in Canada but it has considerable resonance with the findings of this study. NZ politicians and policy makers are not yet calling on NPs to assist the overburdened health system but they are calling for the many changes that NP practice, as outlined in this study, could well lead. Significant focus is being given in the recently released health strategy documents (Ministry of Health, 2016a, 2016b) to the need for services to become integrated across primary, secondary and tertiary boundaries, to the importance of multidisciplinary collaboration and the need to increase wellness preservation. Most importantly the Strategy focuses on moving closer to a more person or patient centred focus, even using the words *people powered* in strategy rhetoric (Ministry of Health, 2016a).

Primary health care NPs in New Zealand often enter employment positions that are structured and funded in an age old manner – one that is privately owned by community based medical practitioners. Largely these service models are based on an acute reactive model of primary care provision with short appointments for fee paying patients. This private business model has perpetuated the domination of biomedicine using a reductionist approach to long

term conditions that is unlikely to make significant inroads into the health of populations, nor to reducing health inequalities. Other NPs are employed in not for profit organisations. While these at times offer more flexibility in service delivery modes, such organisations are often compounded by both new public management systems with frequent changes to management structures, outcome measures, and funding arrangements.

Findings from this current study showed NPs trying to remain true to the tenets of a nursing philosophy, embracing a person/family-centred, collaborative approach within a social justice framework as being central to their practice. Despite a policy framework with funding streams that advocate for such a mode of service delivery, the actualities of health care provision have remained focused on acute presentations and disease-centred care. NPs practice within employment structures that are challenged to recognise or value their potential to deliver far-reaching primary health care services that promote the health and wellbeing of individuals and communities.

Based on the findings of this relatively small study we suggest there would be value in further research to more closely assess the alignment between the transformative potential of NP practice, the goals of current health strategies and the employment structures or setting in which NPs are often required to practice work. Many years of research has provided conclusive evidence of the safety and equivalence of NP practice. Such research whilst valuable offers little hope of achieving the kind of change that countries are asking for as they address 21st century challenges of health service provision. New Zealand, in being relatively new to deploying NPs, has a unique opportunity to utilise their capacity to lead innovative change.

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## APPENDIX C: Publication – Adams & Carryer (2017)

Adams, S., & Carryer, J. (2017). Institutional ethnography: Nurse practitioners in rural primary health care in New Zealand. *SAGE Research Methods Cases Education* (online collection). doi: <http://dx.doi.org/10.4135/9781473998544>

DRC 16



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### STATEMENT OF CONTRIBUTION TO DOCTORAL THESIS CONTAINING PUBLICATIONS

(To appear at the end of each thesis chapter/section/appendix submitted as an article/paper or collected as an appendix at the end of the thesis)

We, the candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated below in the *Statement of Originality*.

Name of Candidate: Sue Adams

Name/Title of Principal Supervisor: Prof Jenny Carryer

Name of Published Research Output and full reference:

Adams, S., & Carryer, J. (2017). Institutional ethnography: Nurse practitioners in rural primary health care in New Zealand. *SAGE Research Methods Cases Education* (online collection). doi: <http://dx.doi.org/10.4135/9781473998544>

In which Chapter is the Published Work: Relates to chapter 4

Please indicate either:

- The percentage of the Published Work that was contributed by the candidate: and / or
- Describe the contribution that the candidate has made to the Published Work:

The article was fully drafted by the candidate. Prof Jenny Carryer made editing recommendations to the final draft.

Sue Adams  
2017.08.28 10:24:27 +12'00'

Candidate's Signature

28 Aug 2017

Date

Jenny Carryer

Digitally signed by Jenny Carryer  
Date: 2017.08.31 12:13:31 +12'00'

Principal Supervisor's signature

30.Aug 2017

Date

GRS Version 3– 16 September 2011



## **Institutional Ethnography: Nurse Practitioners in Rural Primary Health Care in New Zealand**

Contributors: Sue Adams & Jenny Carryer

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### Abstract

In 2012, the lead author, Sue, commenced doctoral study to critically examine the establishment of nurse practitioner services in rural primary health care in New Zealand using institutional ethnography, under the supervision of Jenny. There is an identifiable need for a nurse practitioner workforce, yet the growth has been slow. The research project was designed to explore from the standpoint of nurse practitioners their experiences of registering as nurse practitioners and delivering health services. Institutional ethnography allows for the explication of how the experiences of individuals across multiple local settings are coordinated textually. Reproducible texts, including discourse and written material, are produced by various institutions and organizations across time and place, creating a web of ruling relations. In turn, the activities of individuals in the local situation are consequently organized. This case study explores the ethics review process as encountered during our research. Institutional ethnography is a research approach which is explorative, open-ended, and often participatory and activist in nature, and consequently poses particular concerns for ethics review committees (as may other research approaches) where the research direction is often unknown. However, institutional ethnography also offers a way of explaining how research ethics committees work within the regulatory and institutional ruling relations. There are broadly two parts to this case study. The first provides an overview to institutional ethnography, using our research on nurse practitioners to provide examples; the second part focuses on the process of ethics approval, the need for ongoing ethical consideration, and how this was practically approached.

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### Learning Outcomes

By the end of this case, students should be able to

- Have a rudimentary understanding of institutional ethnography (IE) as an approach to social science inquiry
- Describe how the open-ended nature of IE poses challenges to the ethics review process (ERP)
- Identify solutions and approaches that can be used to facilitate successful ethics review and that demonstrate ongoing commitment to ethical considerations
- Critique the ERP understanding how the ERP itself can organize, limit, or control research

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### Project Overview and Context

#### Background and Entry to the Study

The purpose of this ethnographic inquiry was to critically examine the establishment of nurse

practitioner services in rural primary health care in New Zealand. From the advent of the first nurse practitioners in the United States in the 1960s, there is now a substantial body of international knowledge demonstrating that nurse practitioners provide at least equivalent care to that of doctors. For example, Swan, Ferguson, Chang, Larson, and Smaldone (2015) conducted a systematic review of randomized controlled trials showing the safety and effectiveness of primary care provided by nurse practitioners when compared to doctors. Alison Pirret, in her doctoral research, showed that nurse practitioners had equivalent diagnostic reasoning abilities in complex cases (Pirret, Neville, & La Grow, 2015). A range of studies have also shown that patients are highly satisfied with the care they receive from nurse practitioners (as reviewed by Martínez-González et al., 2014).

Nurse practitioners are experienced nurses who, in New Zealand, hold a clinical masters degree in nursing, are registered in a specific title protected scope of practice, and are all legally authorized prescribers. Nurses have been able to register as nurse practitioners since 2001, with a legislative and policy framework which supports advanced nursing and prescribing practice. Despite this, the growth in the numbers of nurse practitioners working in New Zealand, and particularly in rural primary health care, has been very slow.

Internationally, nurse practitioners have been instrumental in providing services to rural, indigenous, deprived, or marginalized communities, working particularly from a social justice perspective (see, for example, Browne & Tarlier, 2008; Carryer & Yarwood, 2015). Given the levels of health disparity in New Zealand and increasing demand on the primary healthcare services, nurse practitioners were identified as an important workforce development in the government's primary healthcare strategy of 2001 (King, 2001). Both of us, from our differing backgrounds and perspectives, had recognized that there were a range of discourses, and organizational and legislative challenges, that were preventing the establishment of a rural nurse practitioner workforce. Thus, we considered a critical exploration of what was happening at the institutional levels to impede nurse practitioner development to be timely and institutional ethnography (IE) the appropriate approach.

#### **The Research Question**

Knowing the contribution that nurse practitioners could make to health in New Zealand and knowing that there were nurses keen to pursue this, it was puzzling to us that the growth of established positions has been so slow. Our research question evolved to be What is happening organizationally and institutionally that is making it a struggle for nurses to become nurse practitioners and deliver nurse practitioner services in rural primary health care?

It was with this in mind that we chose IE as an appropriate approach to enquiry. We wanted to

understand how the various regulatory, legislative, and professional organizations, along with powerful discourses, were concerting to make it difficult for nurses to establish nurse practitioner services.

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#### The Approach to Inquiry: IE

IE is an alternative sociology founded by Dorothy E. Smith (1999, 2005), a renowned Canadian feminist sociologist. Ian Hussey (2012) described IE as a “Marxist-feminist, reflexive-materialist, qualitative method of inquiry” (p. 2) where the purpose is to reveal how the social world is organized. The aim is to improve the lives of those who are in some way marginalized and excluded by understanding how the institutional ruling relations are operating in people’s everyday lives. IE is critical and political in its approach, providing a way of challenging and transforming the way our social world is powerfully and institutionally governed. Smith describes IE as a way of showing how things happen as they do in our social world and how is it that people in similar local situations that are not connected have similar everyday experiences as they go about their everyday lives.

#### The Ontology of IE

Smith identified that contemporary capitalist societies are controlled textually through the production of texts (visual, written, and oral) and discourses at an institutional level. The texts are reproducible and disseminated widely to people in the local setting through, for example, mass and social media; professional organizations; and health, education, and legislative systems. Individuals in the local setting engage with and activate the texts, and as a consequence, their everyday activities are coordinated institutionally by those texts. Smith’s early research, with her colleague, Alison Griffith, explored how their everyday activities or “work” as single parents of young children was being coordinated by the educational systems and societal discourses (Griffith & Smith, 1987). Beginning from their standpoint, they tracked up and through the institutional layers identifying how their individual mothering experiences and family life were organized by the ruling relations as educational work.

Texts and discourses are produced at an institutional level, including from institutions of government, legislation, administration, and professional authority, as well as academic, historical, and cultural discourses. Together these are known as the institutional or ruling relations. In contemporary society, everyday experiences and activities are inextricably linked to a complex web of institutional relations (see Bisailon’s (2012) glossary of IE terms). In turn, an individual’s everyday activities, which in IE is known as *work*, are organized by those ruling relations. The texts are reproducible and can reach individuals in many similar local settings. The advent of the World Wide Web and social networking has further increased the speed and

reproducibility of these texts.

To illustrate the ontology of IE, we will use an example from a data excerpt from an interview conducted by Sue in our research. The following nurse practitioner worked in an isolated clinic in a small town in New Zealand:

One of the things that got me paid as a nurse practitioner (NP) was that I collected the statistics from five [nurse-led] clinics. The doctor, on his visits, saw about twenty patients in each of the other clinics. But when he came to [the NP clinic] he usually just saw three or four. He actually told somebody that he thought people [in the NP clinic] didn't get sick, but he finally realised how much work I did! There were so many things that I could do, that the others [registered nurses] couldn't do. I could sign off ACC (accident compensation forms), and accidents were a big part of the work because of adventure tourism, farming, fishing, and bad roads; I could do all the repeat prescriptions, [and] all the prescriptions for the initial visits; if I was worried about the children I could wander down to the school and be the public health nurse; I saw the women antenatally ... and six weeks postnatally as the midwife didn't come down to [our area] ... So those statistics were what persuaded them that they should pay me as a NP.

The nurse practitioner is participating in the ruling relations for each activity she undertakes, including legislation, professionalism, health policy and systems, local council, public health, pharmaceutical industry, and so on. Behind each action is a text which is organizing her everyday activities. The nurse practitioner activates the text, sometimes modifying the text within the local context, and in turn perpetuates the ruling relations. Because the texts are reproducible across many local situations, the work, or everyday activities, of nurse practitioners in other locations will be similar. This excerpt highlights the work or action that the nurse practitioner did in order to be recognized and paid reasonably. She also refers to the dominant medical discourse that sick people need to see doctors, which can be tracked back up through the institutional layers to the discourse that nursing work is undervalued and often invisible.

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**Methodology: Application of IE**

**The Problematic: Identifying the Puzzle**

The entry point to an IE inquiry is a puzzle or a problem, called the *problematic*, which is being lived by someone in their everyday world (see Campbell & Gregor's (2004) primer in doing IE). Often the researcher's interest in the inquiry develops from their own experience. In the case of this research on nurse practitioners in rural primary health care, Sue had experienced deep

frustration around the processes to become a nurse practitioner. There was a tension, or reality gap, between the official processes and regulations of becoming a nurse practitioner, and the embodied experience of what actually happened. In IE, this is known as a *disjuncture* and provides the impetus to begin the inquiry and explore the problematic.

Identifying the disjuncture is a critical step in the research process. For example, researchers explored the social organization of nurses' emotional distress in a pediatric intensive care unit from the standpoint of the nurses (McGibbon & Peter, 2008; McGibbon, Peter, & Gallop, 2010). The work that nurses were expected, regulated, and portrayed to do was at odds with their actual work and experiences. This was the disjuncture and entry point to the problematic of the research. The ruling relations, such as the biotechnological prolongation of life, health systems management and documentation, and the hierarchical domination of the medical profession, were controlling nursing work, resulting in considerable stress and distress.

The notion of problematic provides a framework to begin the inquiry from the standpoint of the informants. Smith (2005) states that "[a] problematic is a territory to be discovered" (p. 41), and in this regard can be likened to creating a cartographic map. In the case of our research, the problematic was an interrelated set of questions concerning the struggles that nurses experienced to become registered as nurse practitioners, to be employed, and to establish and maintain nurse practitioner services. As with almost all IEs, the starting point of our inquiry was to interview nurses about their experiences and their actions—what they had to do to become and be a nurse practitioner. The interviewer's job is to explore and analyze the texts, discourses, and their hierarchical power which organize everyday activities up and through the institutional layers. This analytical technique is known as *mapping* (see Turner (2006)] for description and application of mapping).

#### Interviewing

Interviewing in IE is more about "talking with people" and exploring with them their day-to-day work. DeVault and McCoy (2012) described how interviewing in IE is about piecing together a larger picture of how the ruling relations are organizing the work of the informants. The purpose of interviewing is not to generalize about the group of people being interviewed but to complete a map and explicate the ruling relations. From each interview, different pieces of the puzzle will be identified and pursued. Each interviewee provides a partial view. DeVault and McCoy explain,

The process of inquiry is rather like grabbing a ball of string, finding a thread, and then pulling it out. Institutional ethnographers know what they want to explain, but they can discover only step by step whom they need to interview or what texts and

discourses they need to examine. (p. 383)

Each interview builds on previous interviews and often informs the next interviews. In this regard, the analytic process begins during the interview. Perhaps the most salient advice on interviewing was given to Sue by Dorothy Smith at a workshop in Toronto, Canada, in 2012. She noted that if the researcher learnt nothing new from an interview that helped piece together the particular puzzle, then her job as interviewer had not been done well. In every interview, we should be discovering something that further informs the problematic and the way the ruling relations are operating. This mantra additionally ensures that the interviewer listens for new threads of information and pursues those not known about, rather than covering common ground again.

#### **Data Analysis and Further Interviews**

Having completed the initial interviews with informants from the local setting, analysis through the mapping of interviews continued to further explore some of the identified texts and discourses arising from the interviews. Keeping the original research question in focus is essential. Often in IE, a second phase of interviews is conducted to explore the origin of particular texts and discourses. For our research, individuals were identified at regional and national levels (in other words, "higher up the institutional food chain") and interviewed because of their involvement in producing texts for the local situation. Again, the work these individuals do and the texts they produce are similarly coordinated by texts written at a national level, often international, and include policy and legislative texts.

In the data analysis, there were multiple texts and discourses, often contradictory and arising from a range of organizations and institutions. From our research, two prominent and powerful discourses were as follows:

1. The medical professional discourse and how it has diminished the power of nursing texts, including research and strategies, thus devaluing nurse practitioners' work;
2. The neoliberal discourse of self-responsibility which has minimized the importance of nursing work in providing health promotion and reducing health inequalities, and ultimately negated the importance of working from a social justice perspective.

#### **Reviewing the Data Mapping and Findings**

Social science research that is critical, political, or participatory strives to improve the social world of those individuals who are central to the study. In this research, the nurses were the primary informants, and it was from their experiences that the institutional ruling relations could be explored. Being involved in research can itself be empowering as the researcher and

informant engage in dialogue exploring tensions and issues in their everyday world and develop shared understandings (DeVault & McCoy, 2012). However, it is also important to revisit the findings with nurses and nurse practitioners to ensure they have visibility of the mapping of the institutional ruling relations. This in turn gives them, both as individuals and as groups of professionals, the opportunity to challenge, expose, and engage differently with the texts and discourses organizing their daily lives.

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### IE and Research Ethics

The earlier sections of this case study have provided an overview to IE and the context and process of our research exploring the establishment of nurse practitioners in rural primary health care in New Zealand. The following sections focus on the research ethics of an IE, the issues that arose during our IE research, and the approach we took to overcome those issues. First, we provide a brief introduction to the ethics review process (ERP) showing how such processes are textually mediated by the ruling relations, coordinating the work that we, as researchers, do and, second, how we approached particular ethical issues during the research process. Note that the bodies responsible for administering the ERP are variously known as research ethics committees, research ethics boards, institutional review boards, or hospital or institutional ethics committees.

### Ethics Review Process

The consideration of ethics in social science research is critical to protecting individuals, communities, and environments while endeavoring to make the social world in which people live a better place. The behavior of researchers, both biomedical and social science, has, on many occasions, been unethical, causing significant harm to participants (see Israel (2015) for a thorough review of this). The result has been increasing regulation over ERPs worldwide. However, it has particularly been unethical medical experimentation by doctors that has led to the development of the founding codes and guidelines used in ethical regulation, for example, prisoners experimented on in Nazi concentration camps (1939-1944), African American men withheld from treatment in the Tuskegee Syphilis Study (1932-1972), elderly Jewish people unknowingly injected with cancer cells in New York (1963), and in New Zealand, an experiment to not treat women who had pre-cancerous cervical smears (1955-1976). The codes consequently written, termed basic or regulatory texts in IE, include the Nuremberg Code (1947), the Declaration of Helsinki (1964), and the Belmont Report (1979) and frame ethics from a biomedical perspective. The key ethical principles arising on which current research regulations are based are as follows:

- *Respect for people*—includes protecting the autonomy of all people in their decision-making and contribution to the research, known as *informed consent*.
- *Beneficence*—research should ensure that the welfare of participants is maintained. However, interpretations in ERPs tend to focus on “do no harm” rather than research which can facilitate the welfare of participants (such as in IE and other participatory research).
- *Justice*—includes the fair and equitable way in which participants are selected, and any costs and benefits are equally distributed to participants.

These principles, along with how they need to be applied to research practice, through informed consent, the assessment of risk and benefits, and the selection of subjects, are described in the Belmont Report (1979).

Social science research has largely not been considered in the development of ethical regulations, internationally and nationally, which has led to widespread dissatisfaction with ERPs that prevail in universities and large teaching hospitals in countries such as the United Kingdom, the United States, and Canada. The result of the one-off ethics approval process has resulted in some researchers feeling alienated from the ERP, approaching the review strategically, and potentially “playing the game” or even engaging in deceitful practices. For further critique of these issues, see the work of Mark Israel (2015), Martyn Hammersley (2009), and McAreavey and Muir (2011). In IE, the dissatisfaction expressed is a tension, or disjuncture, between the regulatory institutional processes and the everyday experiences of researchers engaging with the ERP.

IE, and other participatory and activist research approaches, particularly struggle with the existing ERPs, designed largely for positivist research, due to the open-ended nature of the research. Carole Truman (2003) undertook an IE exploring the use of a community gym for people with, or at risk of, developing mental health problems. In her article titled “Ethics and the ruling relations of research production,” she drew attention to the ongoing power differential between the experts and the participants of the research. She stated that research ethics committees have “gained a powerful role as gatekeepers within the research process ... assuming the role to ‘protect’ dependent and ‘vulnerable’ research subjects” (para 1.1). Truman went on to argue that the ERP limits the researcher’s opportunity to engage with participants in a democratic way, not only maintaining the researcher’s position of power as the expert but also potentially limiting the acquisition of new knowledge.

The key issues raised that needed to be addressed for the ERP for our research were the following:

1. Gaining ethics approval for an IE where participants and the line of questioning were largely unknown at the outset;
2. Ensuring that the research can progress (ethically) and at the same time pursuing the problematic as it further developed and refined through the research process;
3. Maintaining ongoing ethical integrity to appropriately deal with ethical considerations as they arose during the research process.

#### **Engaging With the ERP**

Approaching the research ethics application form raised a level of anxiety and frustration that the research, using IE, did not neatly fit into the boxes specified. However, as McAreavey and Muir (2011) eloquently pointed out, we have two choices: either to play the game, fill in the form, and get the job done, or to engage collaboratively with the ERP. Paradoxically, while researching using IE was creating the problem in completing the ERP, by applying the ontology of IE to the ERP enabled greater understanding that the disjuncture being experienced was as a result of the ruling relations creating the forms and governing the actions of the researchers.

No "formal" IE of the ERP was undertaken, but we did review (albeit briefly) the various codes and reports made available on the University's website and informally mapped where those had originated from. Our engagement with the literature on the ERP supported greater comprehension of the discourse of ethics in social science, including the challenges made to the ERP by some social science researchers as described earlier. We developed an understanding of how these documents had arisen, the actions of earlier research (misadventures) that resulted in the texts, and consequent various ethical regulations. We were aware there would be institutional processes and discourses which would be invisible but were controlling the work and actions of the ethics committee.

#### **ERP: Practical Lessons Learned**

With this knowledge of the ruling relations and how the research ethics committees were themselves being institutionally controlled by the ruling relations, we adopted the following approach to the ERP:

1. View the ERP as a learning opportunity to better understand ethics regulation and the ethical principles underpinning the ERP;
2. Accept that this was a regulatory process, the origins of which were to ensure participants were protected and respected through the ERP, as well as protecting the institution from adverse events and publicity;
3. Approach the ethics committee collaboratively, seek their input and knowledge, and create

- a dialogue to explore ethical issues;
4. Demonstrate knowledge of ethics and the ability to act ethically, particularly in the recruitment of participants and in the line of questioning, to ensure ethical principles were honored;
  5. Demonstrate how to consider and take responsibility for ethical issues as they arose through the research process recognizing that social science research is situational and contextual.

The experience for Sue at the research ethics committee meeting was extremely positive. Sue took time to explain IE and discuss the open-ended nature of the research process and how she would attend to ongoing ethical considerations. She described her standpoint as a nurse and the importance of exploring the issue from the perspective of those working in the local situation. She also emphasized that the interest of this research was ultimately to find ways of increasing the nurse practitioner workforce in New Zealand, taking a social justice perspective. Ultimately, through discussion, Sue came to believe the committee reached a point where they felt they could trust her as a researcher to work ethically.

#### Ongoing Ethical Considerations

IE arose from Smith's (1987) earlier work to develop a sociology for women. She had been a significant player in the women's movement in North America and as a sociologist was highly concerned about research being conducted by those (mostly White men) whose standpoint was located within the ruling relations. In contrast, IE research begins from the standpoint of the people in the local situation and their experiences. For example, Rankin and Campbell (2009) explore how nursing work and knowledge are being subordinated by hospital regulations and reform. As their interviewing progressed, they described how they paid attention to experiences that "trouble[d]" (p. 10) the nurse, which led to questioning that they would not at first anticipate. Inevitably, this questioning raises ongoing ethical considerations, as the interviewer probes areas, often of distress, tension, and conflict, with the informants. Yet, it is these disjunctures which provide the entry point to the exploration of the ruling relations.

Recalling Smith's words that new information should arise from each interview, each interview is unique, revealing particular issues and concerns that cannot be anticipated by the researcher. For example, during one of Sue's interviews with a nurse practitioner, we were talking and exploring a particular tension that the nurse practitioner had experienced between her own nursing knowledge and that of her managers. The nurse practitioner had worked to establish a rural clinic to particularly address some of the health needs of local Māori (indigenous) women and children, including domestic violence, cost of contraception, unwanted pregnancy, and

children's skin and respiratory infections. The project had been stopped. The nurse practitioner was particularly concerned about how we would deal with these data in the analysis and write-up.

The dilemma faced was that this seemed to be a particularly useful issue, or disjuncture, through which to explore the ruling relations, yet the nurse practitioner was raising the potential risk to her anonymity. Our ongoing discussion centered on how this material could be used without identifying her and how to do so in a way that was respectful to all those concerned. Returning to the purpose of IE enabled Sue to explain that while the nurse practitioner was aware of the local texts, the ruling relations extend beyond the local situation, and it is the institutional relations and actions that are of interest, which are at present outside our (both the nurse practitioner's and the researcher's) consciousness. We also agreed that there would be certain material from her transcript that would be paraphrased and used without assigning any identifiers.

A second example was again concerned with protecting the anonymity of the informant. The intent of the research is ultimately about how we can increase the nurse practitioner workforce in rural primary health care. The community of nurse practitioners is small, and therefore, protecting anonymity was a significant concern throughout the research. However, it was the ongoing dialogue with this particular informant, following her receipt of the interview transcript, which resulted in a more defined strategy than had previously been described in the ERP. Just referring to the use of pseudonyms (and the various requirements of taping and storage), as per the participant information sheet required for the ERP, was totally inadequate.

#### **Practical Strategies Developed**

Some of the strategies that we incorporated along the way into the research process, analysis, and write-up included the following:

1. Be aware of the regulatory ruling relations of ethics and the power imbalance this creates. Share and open up a dialogue with the informant about the key ethical concerns and what can be done to ensure the informant feels safe. This may happen over a number of weeks.
2. Continue to listen for ethical concerns expressed by informants both during the interview and at other stages of the research process.
3. Update the informants regularly on the progress of the research, explaining how their information is allowing the exploration of the institutions and organizations and their coordinating power. In the earlier stages of the research, this was not done adequately, and it was through feedback with the informants that we improved the process.
4. Use broad descriptors of the informants as a group, rather than individually, ensuring that

examples of mapping and quotes cannot be identified.

5. Ensure representation by participants from across New Zealand and define location by district, rather than by local area.
6. Describe the concern regarding anonymity expressed by informants in the thesis and the decision to only use pseudonyms attached to data which does not connect the data to an identifiable location or individual.

As our research has progressed, understanding of the necessity in IE of keeping the informants and their everyday experiences in view has continued to grow. By maintaining this position, we have become increasingly aware of protecting individual informants and at the same time wanting to ensure that the research did justice to the nurses involved. As researchers, and nurses, we have felt privileged to hear their stories and gain some insight into the work they have done to achieve all they have. We believe this has also facilitated attention to ethical considerations.

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#### Conclusion: IE and Ethics

Smith described IE as an alternative sociological approach to inquiry providing ontological, epistemological, and methodological direction to explore the social world in which we live. While we were certain that IE provided the direction to critically examine the establishment of nurse practitioner services in rural primary health care in New Zealand, we had not anticipated how IE could also provide insight into the research process itself. In this case study, we briefly introduced IE and its application to our research, and then focused on an arising issue—the ERP—and the relevance of the ontology of IE to explore and understand this issue. The latter was an unexpected discovery in our journey.

Applying an IE approach to the research process enabled a theoretical understanding of the ruling relations of the ERP which in turn translated into practical action. This is an exemplar of the very purpose of IE which is to explore how the ruling relations textually regulate and coordinate our everyday activities or work. In turn, we engage with and activate, often unconsciously, those ruling relations. Gaining insight and understanding into the ruling relations of the ERP enabled us as researchers to choose how to consciously engage with the ruling relations and the texts which they produced. Rather than seeing the ERP as a regulatory hurdle to jump through, IE enabled us to approach this with a fuller understanding of the ERP and resultant texts. This resulted in learnings that had not been anticipated.

One of the pleasures of doctoral study is the opportunity for researchers to immerse themselves within a particular research framework and approach. Doctoral research is about

adding new knowledge, both to the topic and to the research approach, framework, or methodology used. This case study, we hope, has shown a little of both.

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**Exercises and Discussion Questions**

1. In this case study, we discuss how the institutional ruling relations are coordinating the work of nurses as they strive to become nurse practitioners. Discuss how certain discourses within your area of work or research are controlling and organizing the daily lives of marginalized people.
2. Dorothy Smith talks about intertextual hierarchy. What are some of the regulatory, or boss texts, present in your area of work or research? Are there boss texts which are competing or contradictory? How are these texts given their power?
3. In IE, the ruling relations are explored from the experiences of the person in the local situation, often from a place of disjuncture or tension. As a researcher, how are the ruling relations coordinating, organizing, or governing your work and everyday experiences? What are the tensions that you notice between how the world should be (according to the ruling relations) and the reality of your experiences?
4. The ERP was originally established to regulate positivist research. How do ERPs coordinate the experience of social science researchers in your area? How, if at all, does the ERP control, or even limit, social science research in your area of research?
5. Ongoing ethical considerations are contextual and situational in many social science research approaches. Describe the key ethical principles and discuss how these can be applied to the ongoing research process.
6. Institutional ethnography was used to understand how the regulatory ERP came about and how ethics review committees are themselves textually controlled by the ruling relations. How might you apply this knowledge to future ERPs?

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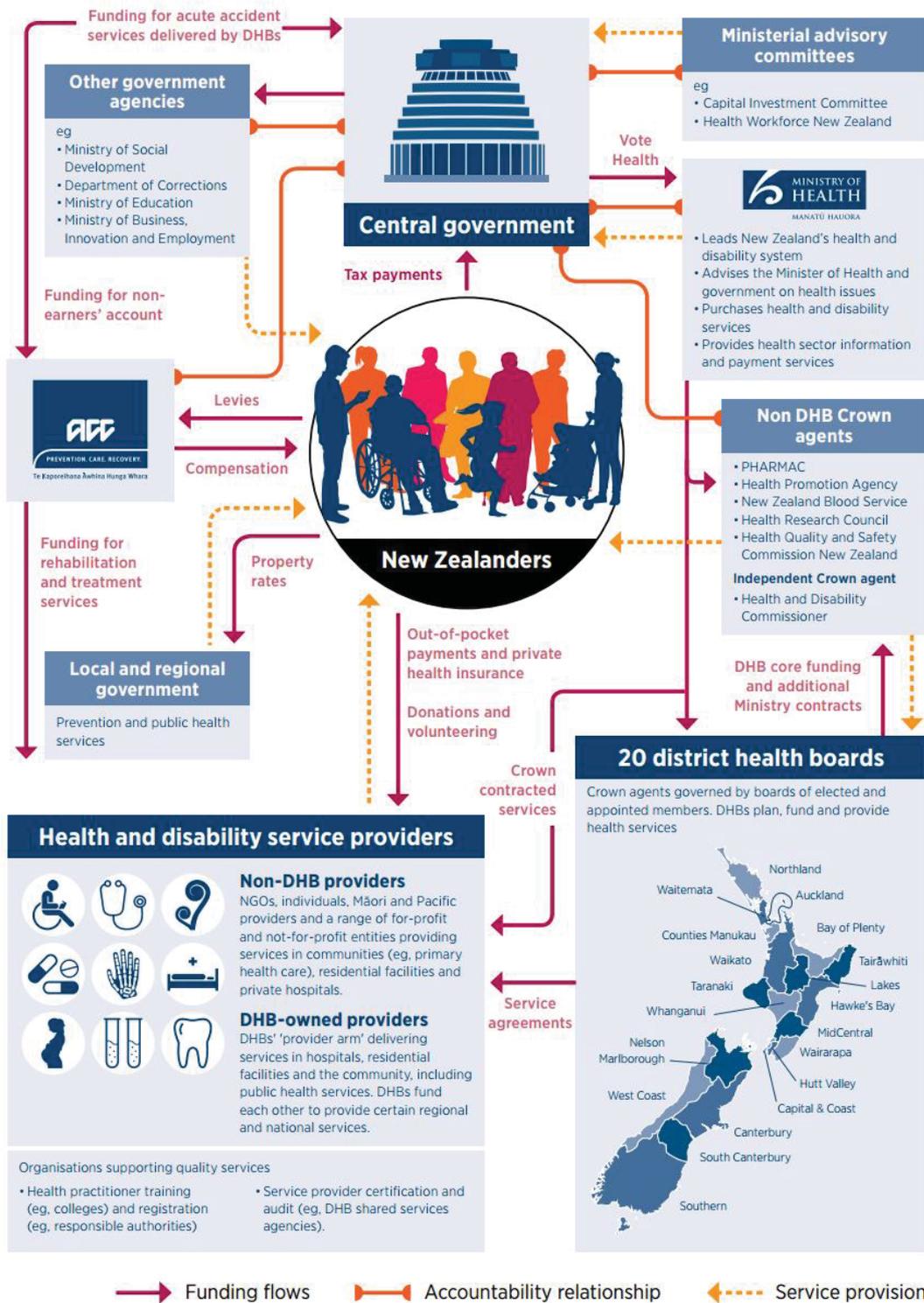
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# APPENDIX D: New Zealand Health and Disability System

## Overview of the New Zealand health and disability system



From: New Zealand Health Strategy: Future Direction (Ministry of Health, 2016c, p. 38)

# APPENDIX E: Scaffold Map drawn in 2012



## APPENDIX F: Ethics Forms and Consents



MASSEY UNIVERSITY  
NEW ZEALAND

23 August 2012

Sue Adams  
c/- Dr J Carryer  
College of Humanities and Social Sciences  
Massey University  
Albany

Dear Sue

**HUMAN ETHICS APPROVAL APPLICATION – MUHECN 12/062**  
**Nurse Practitioner (NP) Services in Rural Primary Health Care: Establishing the Workforce and Service**

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Ralph Bathurst  
Chair  
Human Ethics Committee: Northern

cc: Dr J Carryer  
College of Humanities and Social Sciences

Te Kunenga  
ki Pūrehuroa

Research Ethics Office  
Private Bag 102 904, Auckland, 0745, New Zealand Telephone +64 9 414 0800 ex 9539 [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz)



## Nurse practitioner (NP) services in rural primary health care:

Establishing the workforce and service.

### Information Sheet for Participants

#### An Introduction to the Researcher

My name is Sue Adams and I am a doctoral student doing my PhD. I have worked in primary health care nursing for many years, including both practice and leadership. I have a particularly strong interest in rural primary health care and the role that nurses, and particularly nurse practitioners (NPs) have in providing rural primary health care services. I am currently a senior lecturer in nursing at Massey University.

#### Project Description and Invitation

The purpose of the research is to explore the work that people in primary health care services have to do to establish NP services. This is both the work that nurses themselves have to do to become a NP in a rural primary health care service, and the work that other health care providers have to do to establish a NP service. I intend also to explore the texts, which may be policies, documents, media or journal articles, which may influence to varying extents the actions of people at the local level of health service provision.

By doing this I hope to gain a better understanding of how the organisations and institutions that are involved or engaged in NP development facilitate, hamper or impede the development of NP services in rural primary health care.

Ultimately, the aim of this research is to identify ways and make recommendations to those institutions and organisations to promote the establishment of NP services in rural primary health care.

I would very much appreciate the opportunity to interview you in your capacity as a NP candidate, a NP, a primary health care provider who has been significantly involved in establishing a NP service, or a locally based advocate and leader for establishing NP services.

#### Participant Identification and Recruitment

You have been identified as possibly being willing to participate in this research through networks, or your local PHO or DHB, because of your involvement in establishing NP roles or services. In total, I am hoping to interview between 15 and 20 people.

#### Project Procedures and Data Management

You are invited to participate in this study by agreeing to be interviewed by me about the work and activities you have done to either become a NP or establish a NP service.

- Your involvement in the research would involve an interview of one to one and half hours in length, at a time and place mutually agreeable.
- With your permission, I would like to audio record the interview. The audio recording would be saved as an audio file which would then be transcribed.
- I will send the transcript of the interview back to you for confirmation within one month of the interview. You have a right to delete any parts of the transcript or add any information you think appropriate.
- I will ask that you return the transcript to me within two weeks of receiving it, or confirm by writing that you are willing for the data to be used in this research. You have a right to withdraw from the study at any time until the transcript is returned to me or you have confirmed that I may

use the data. The data will be used for my thesis, and for any publication or presentation that may arise in association with this study.

- The audio recording will be converted to an anonymous audio file, which will be transcribed within one month of the interview. An electronic copy of your transcript and the audio file will be saved anonymously on my personal hard drive which is password protected. A paper copy of the transcript will be stored in a locked filing cabinet and your name changed to an agreed pseudonym. These will be kept separately from the consent forms. Your place of employment and role will be referred to in the study by an agreed generic title.
- At the completion of the study I will return the audio file and transcript to you, or alternatively, I will destroy the audio file and transcript after five years (requirement for auditing purposes).

### Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study up until the time that the transcript has been returned to me, or you have confirmed in writing that the data from your interview can be included in the study;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the audio recorder to be turned off at any time during the interview.

### Interview Content and Themes

The interviews will be conducted in an unstructured way. My interest and questioning will be around the work that you have done to either become a NP or to establish a NP service in rural primary health care. I will be interested in what actions you have taken or are taking. I will also be exploring with you what texts (documents, policies, media, articles, etc) enter into your local situation from various institutions, organisations and professional bodies, which contribute or coordinate what you do (or in some instances don't do). So after an initial question inviting you to tell me what you have done or are doing, the interview will continue to be more of a conversation between us, exploring the work you do and what texts direct or coordinate that. I will be drawing on your knowledge and experience, pursuing questions as they arise in our conversation.

I will be contacting you within the next week to ask whether you have any further questions about the study and whether you are willing to consent to participate in it. In the meantime, if you have any questions, please do not hesitate to contact me, or my supervisor.

Thank you for taking the time to consider participating.

#### Researcher

Sue Adams RN MSc  
Mobile: 021 388 449  
[sue.adams2@xtra.co.nz](mailto:sue.adams2@xtra.co.nz)  
[s.adams@massey.ac.nz](mailto:s.adams@massey.ac.nz)

#### Supervisor

Prof Jenny Carryer  
School of Health & Social Services  
Massey University, Palmerston North.  
[J.B.Carryer@massey.ac.nz](mailto:J.B.Carryer@massey.ac.nz)  
06 356 9099 ext 7719

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/062. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).



MASSEY UNIVERSITY  
COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

**Nurse practitioner (NP) services in rural primary health care:  
Establishing the workforce and service.**

**Participant Consent Form**

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree / do not agree to the interview being audio-recorded.

I wish / do not wish to have my recordings returned to me.

I wish / do not wish to have the transcript returned to me.

I wish / do not wish my ethnicity to be identified in the final report.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... Date: .....

Full name printed: .....

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application **12/062**. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern. Telephone 09 414 0800 x 9750, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).



**Nurse practitioner (NP) services in rural primary health care:  
Establishing the workforce and service.**

**Authority for the release of transcripts**

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name - printed \_\_\_\_\_

**Researcher**  
Sue Adams RN MSc  
Mobile: 021 388 449  
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06 356 9099 ext 7719

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/062. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

## APPENDIX G: Peterson's letter to Nursing Council of New Zealand



26 February 2015

Carolyn Reed  
Chief Executive  
Nursing Council of New Zealand  
PO Box 9644  
Wellington 6141

By email: [carolyn@nursingcouncil.org.nz](mailto:carolyn@nursingcouncil.org.nz)

**Consultation on the Scope of Practice and Qualifications: Nurse practitioner**

Dear Carolyn

The New Zealand Medical Association (NZMA) welcomes the opportunity to provide feedback to the Nursing Council on the above consultation. The NZMA is the country's largest voluntary pan-professional medical organisation with approximately 5,000 members. Our members come from all disciplines within the medical profession and include general practitioners, doctors-in-training, specialists, and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders. Our submission has been informed by feedback from our Advisory Councils, members and the Board.

1. At the outset, we acknowledge the value of nurse practitioners, nurses and the various other members of the multidisciplinary health care team, working collaboratively with doctors, through the patient-centred medical home. This integrated model of patient care has been proven to deliver improved outcomes for patients and is cost-effective for the health care system. We have a number of concerns with the proposals being put forward by the Nursing Council, particularly in relation to changes in scope of practice that may favour more independent practice. We elaborate on our concerns in the following paragraphs.

2. The NZMA is not convinced by the Nursing Council's attempt to cite workforce considerations as the major rationale for proposing an expanded scope of practice for nurse practitioners. While it is true that New Zealand is facing increased pressure in primary health care with an ageing GP workforce, good progress is being made to address this issue with more doctors being trained in general practice than in recent years. For example, in 2007, 69

new trainees entered the GP training programme while the 2014/15 intake had 172 new trainees, with the expectation that even more will enter the programme in coming years.<sup>1</sup>

3. By far the largest shortage in the health care workforce in the future will be for nurses. An analysis of the nursing workforce, taking into account predicted changes in population size and structure, suggests that there will be a shortage of 15,000 nurses in New Zealand by 2035.<sup>2</sup> We feel that the Nursing Council and other relevant organisations should focus on the predicted shortage of nurses as a priority. Expanding the scope of practice for nurse practitioners will not help meet this predicted shortage and may even exacerbate the gaps in traditional nursing roles.

4. The NZMA has concerns that proposed wording in the new scope of practice could see a shift to nurse practitioners working autonomously and independently rather than collaboratively as part of a team. Independent practice is likely to lead to increased fragmentation of patient care and, consequently, poorer patient outcomes. We submit that the Nursing Council consider rewording the proposed new scope of practice such that it makes it clear that collaborative and integrated health care teams are the preferred models of care, particularly in the primary care context.

5. We have some discomfort with the proposal to remove the requirement for a specific area of practice and introduce a broader generic scope of practice. We note that the Nursing Council has a requirement for nurse practitioners to complete a minimum of 4 years of clinical practice in a specific area of practice as part of the prescribed qualification. This educational requirement confers nurse practitioners expertise within a specific area of practice (though this does not necessarily correspond with a practitioner's prescribed scope of practice). While replacing a specific prescribed scope of practice in favour of a broader generic scope of practice may indeed reduce barriers to the flexibility and utility of the nurse practitioner role, we have some concerns at what this may mean for public safety, particularly if accompanied by a move to practice independently, outside of a team.

6. The NZMA has reservations at the proposed extension of the scope of practice to include "the diagnosis...of complex medical conditions". While we are aware that the current scope of practice for nurse practitioners already encompasses diagnosis, we do not believe that an extension to this aspect is warranted. Nurse practitioners are an important part of the health care team but we do not feel that they should substitute for a fully trained doctor, particularly where the diagnosis of complex medical conditions is concerned. The education and training of doctors and nurse practitioners are substantially different, and doctors and nurse practitioners are not interchangeable in providing the full depth and breadth of services. The Consensus Statement on the Role of the Doctor, endorsed by 14 organisations, identifies diagnosis as a key feature of a doctor's expertise in medical practice (see Attachment 1).<sup>3</sup> The statement emphasises that doctors must take ultimate responsibility for medical decisions and diagnoses in situations of complexity.

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<sup>1</sup> RNZCGP. 2014 RNZCGP Workforce Survey released. 10 December 2014. Available from <http://rnzcgp.org.nz/assets/documents/Publications/RNZCGP-workforce-survey-media-release-FINAL.pdf>

<sup>2</sup> Dr Ganesh Nana, Fiona Stokes, Wilma Molano and Hugh Dixon (June 2013), NEW ZEALAND NURSES: workforce planning 2010-2035, BERL, Wellington. Available from <http://www.nursingcouncil.org.nz/News/The-Future-Nursing-Workforce>

<sup>3</sup> Available from [http://www.nzma.org.nz/\\_data/assets/pdf\\_file/0006/16980/Consensus-statement-on-the-role-of-the-doctor-in-New-Zealand-November-2011.pdf](http://www.nzma.org.nz/_data/assets/pdf_file/0006/16980/Consensus-statement-on-the-role-of-the-doctor-in-New-Zealand-November-2011.pdf)

7. We welcome the Nursing Council's proposal to remove the statement on clinical leadership in the proposed new scope of practice. It is our view that doctors are in the best position to assume the role of clinical leadership of multidisciplinary teams. This view is also reflected in the Consensus Statement on the Role of the Doctor and is shared by the Canadian Medical Association<sup>4</sup> and the American Academy of Family Physicians.<sup>5</sup>

8. With respect to qualifications, the NZMA is supportive of a clinically-focussed dedicated Masters programme with the appropriate quantity and quality of supervised clinical learning time. We suggest that greater emphasis in the Nursing Council's draft programme outcomes for nurse practitioners be given to the foundations of nursing, which should not be lost by nurse practitioners, regardless of how advanced their education and clinical training.

9. From a patient perspective, understanding the respective scopes of practice of the various health care providers they encounter is important. Blurring of these scopes and the proliferation of new health care roles may be potentially confusing for patients. We believe that the solutions to the challenges facing health care in New Zealand are complex but that they should fundamentally involve more doctors and more nurses working together in integrated, co-ordinated, GP-led health care teams through the patient-centred medical home.

10. Finally, we refer the Nursing Council to the NZMA position statement on the Principles of Health Workforce Redesign (see Attachment 2),<sup>6</sup> which stipulates a number of the principles that we believe the Nursing Council should consider as part of its review on the scope of practice and qualifications for nurse practitioners.

We hope that our feedback on this important consultation is constructive and would welcome the opportunity to meet with the Nursing Council to discuss this or any other issues that are relevant to ensuring the best health outcomes for all New Zealanders.

Yours sincerely



Dr Mark Peterson  
NZMA Chair

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<sup>4</sup> Canadian Medical Association. Achieving patient-centred collaborative care. Available from <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-02.pdf>

<sup>5</sup> American Academy of Family Physicians. Primary care for the 21<sup>st</sup> century. September 2012. Available from [http://www.aafp.org/dam/AAFP/documents/about\\_us/initiatives/AAFP-PCMHWhitePaper.pdf](http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf)

<sup>6</sup> Available from [http://www.nzma.org.nz/\\_data/assets/pdf\\_file/0018/1458/Principles-of-Health-Workforce-Redesign-2013.pdf](http://www.nzma.org.nz/_data/assets/pdf_file/0018/1458/Principles-of-Health-Workforce-Redesign-2013.pdf)