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**Advanced Nursing Practice and the Nurse Practitioner: New Zealand
Nursing's Professional Project in the Late 20th Century**

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

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Abstract

Beginning with the question, “what are the forces and voices influencing the meaning of the concept, and the development of advanced nursing practice in New Zealand in the 1990s”, this thesis uses an historical sociological approach to explore what New Zealand nursing is becoming and what it is ceasing to be. Through the examination of New Zealand nursing history from 1860 through the first years of the 21st century, seven historical understandings of the meaning of ‘advanced’ nursing practice emerged: nurses with higher education; nurses with more than one type of registration; community nurses; nurse educators and administrators; specialty nursing; a career hierarchy based on further education, experience and clinical focus; and the contemporary Nurse Practitioner. The thesis argues that each of the earlier historical connotations of advanced nursing practice is reflected in the Nurse Practitioner.

The analysis of this broad scope of New Zealand nursing history, including a case study of the interpretation and implementation of contemporary advanced nursing practice, reveals essential themes of profession and professionalisation; politics and political sophistication. Drawing on theoretical perspectives from sociology, political science, and nursing, these concepts are further analysed, and developed into a representational framework. This conceptualisation depicts critical factors for nursing to achieve its preferred position in the context of time. Therefore, this study is also an exploration of New Zealand nursing’s professional project¹.

This thesis illustrates that while the course of action of a professional project is not always clear or deliberate for all the members of the profession, it nevertheless has a coherence that may be seen *ex post facto*. It is argued that what became the drive for the development of New Zealand’s Nurse Practitioner and the expansion of nursing’s jurisdiction at the turn of the 21st century, began long before the 1990s. The importance of history to understanding the past, the relevance of history to the shape of the present, and the significance of history’s influence on the future are affirmed.

¹ A professional project is the process through which an occupational group gains control over the education and entry to practice of practitioners; secures legitimacy through the state and the public; achieves self-regulation over its practice; and secures, maintains and extends a market, or jurisdiction for itself.

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**Advanced Nursing Practice and the Nurse Practitioner: New Zealand Nursing's
Professional Project in the Late 20th Century**

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Chapter 1: Whither Advanced Nursing Practice in New Zealand?

History is the archive, the drawing of what we are and what we are ceasing to be, whilst the current is the sketch of what we are becoming.²

Introduction

The above metaphor was an early inspiration in this research. I saw Deleuze's use of the word "current" with both its intended meaning as "the present", and also as the noun referring to a river current. The current as the present - as a sketch of what we are becoming, and the current as a flow of water in a river - are themes throughout this thesis. The present, in this instance, refers to the emergence of a professional discourse and political movements in New Zealand in late 1990s around "advanced nursing practice". These developments were the stimuli for this thesis.

A river current may also be a metaphor for historical research. Like historical research, a river's pools and its movement contain mystery; the different perspectives of those in and around the river contribute to its understanding; and a journey along the river leads to discovery. This study began with the question "what are the forces and voices influencing the meaning of the concept, and the development of advanced nursing practice in New Zealand in the 1990s?" Answering the question has required a journey along an extensive river of time – from the mid-1800s to the turn of the 21st century. This thesis examines what nursing is becoming, and what it is ceasing to be.

History provides evidence, contributes to the development of collective memory, and counteracts cultural amnesia. As a relatively young nation, one that saw itself as a British colony at least until the 1960s,³ New Zealand often subjugated its own history to that of Britain. Consequently, what historian Michael King described as a "sandcastle culture" developed, where,

² Deleuze, in Nelson, S. (1997). Reading nursing history. *Nursing Inquiry* 4,(4), 229.

³ King, M. (2003). *The Penguin history of New Zealand*. Auckland: Penguin Books, 488.
Belich, J. (2001). *Paradise reformed: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press, 321.

our many small constructions are completed, admired, and then washed away, unknown to those who follow. A decade later other people do the same things, imagining that it is for the first time. Such a process – such cultural amnesia – handicaps us because it prevents building on sound precedents or harnessing experience already tested.⁴

In the same vein as King, Joan Lynaugh referred to nursing's history as its "cultural DNA".⁵ In these ways, history enables us to build on what has gone before. An historical interpretation may also provide more overt action-oriented dimensions.⁶ It can illustrate models for the development of leaders, contribute to the profession's understanding of strategic planning, and to its development of political sophistication. This study develops a framework for these dimensions.

To discover the forces and voices influencing the meaning of the concept of advanced nursing practice, and its development in New Zealand in the 1990s, this thesis examines various eras in New Zealand nursing, and the movements that informed and shaped them. It also explores the experiences and impressions of nursing leaders, and the positions taken by nursing organisations relating to key issues and defining moments in New Zealand nursing. While this thesis explores the work of many leaders, it does not set out to be a history of "great persons" – that is, it does not emphasise biographical studies of New Zealand nursing leaders. However, within the thesis' analysis of the development of advanced nursing practice, particular leadership qualities were discerned which this study characterises as nursing policy entrepreneurship⁷ and political sophistication.⁸

⁴ King, M. (1985). *Being pakeha*. Auckland: Hodder and Stoughton, 186-187.

⁵ Lynaugh, J. (1996). Editorial. *Nursing History Review*, 4,1.

⁶ Fitzpatrick, M. L. (1993). Historical research: The method. In P.L. Munhall & C.O. Boyd. *Nursing research: A qualitative perspective*. (pp. 350-371). New York: National League for Nursing, 362.

⁷ Kingdon, J. W. (1995). *Agendas, alternatives and public policies*. New York: Addison Wesley Longman, Inc.

⁸ Cohen, S., Mason, D., Kovner, C., Leavitt, J., Pulcini, J. & Sochalski, J. (1996). Stages of nursing's political development: Where we've been and where we ought to go. *Nursing Outlook*, 44(6), 259-266.

What began as an inquiry around contemporary and historical understandings of advanced nursing practice and the forces shaping those expressions, also became a study of New Zealand nursing's professional project – its drive to achieve a preferred position.⁹ Therefore, there are several streams in this New Zealand nursing history. In one stream, there is an examination of the development of seven identified historical connotations of advanced nursing, and an exploration of how these connotations have echoed through time. In another, there is an exploration of New Zealand nursing's development, with particular reference to features of a professional project. Lastly, a case study of the New Zealand interpretation and implementation of a contemporary version of advanced nursing practice is presented.

These three streams were developed out of my examination and analysis of a broad sweep of New Zealand nursing history - from the colonial period just prior to the arrival in the late 1870s and 1880s of the first nurses trained in the Nightingale system - to the early 21st century. The particular lens of advanced nursing practice provides a special perspective. Each of these two aspects differentiates this study from most other nursing histories.

The 'present time'

In 1998, a flurry of documents, proposals, and decisions were released which gave impetus to developments in New Zealand nursing. Emanating from the Government, the Nursing Council of New Zealand (the statutory body for New Zealand nursing), and Nurse Executives of New Zealand (an organization of the most senior clinical nurses), these initiatives related to the development of what was being termed "advanced nursing practice".

*Developing and Supporting Advanced Practice Roles: Clinical Nurse Specialist, Nurse Practitioner*¹⁰ was published by the Nurse Executives of New Zealand (NENZ)

⁹ Larson, M. (1977). *The rise of professionalism*. Berkeley: University of California Press, 6.
Macdonald, K. (1995). *The sociology of the professions*. London: Sage Publications, 8.
Witz, A. (1992). *Professions and patriarchy*. London: Routledge, 5.

¹⁰ Nurse Executives of New Zealand. (1998). *Developing and supporting advanced practice roles: Clinical nurse specialist, nurse practitioner*. Auckland: Author.

in April. In a circular to nurse educators, Jocelyn Peach, Secretary of NENZ explained that the booklet was,

prepared to stimulate discussion and to use in lobbying with the education sector regarding programmes which meet the needs of the service sector.... We believe that advanced nursing practice roles have the potential to enhance the health care for communities in New Zealand and that the ideas in the booklet can ensure that the ideas become reality.¹¹

In May 1998, the Nursing Council of New Zealand published *Framework, Guidelines and Competencies for Post-Registration Nursing Education*. Its purpose was to establish a “national direction for the formal development and recognition of post-registration nursing education” and to “support the portability of specialty and advanced nursing practice qualifications both nationally and internationally”.¹² Significant to “post-registration nursing education”, the Nursing Council also confirmed at its May 1998 meeting, that entry to the Register of Nurses would be via completion of a bachelor’s degree in nursing. The degree, as an entry-to-nursing-practice qualification had only been available in New Zealand since 1993.

In February 1998, the Minister of Health Bill English established a Ministerial Taskforce on Nursing, to consider the “obstacles to the nursing profession realising its full potential with respect to health care delivery”.¹³ Before the Taskforce had completed its deliberations, English made a further announcement - on May 12, 1998, International Nurses’ Day, he advised his intention to introduce legislation extending prescribing rights to nurses.

Three years later, in March 2001, Annette King, the Minister of Health, endorsed a Nursing Council of New Zealand framework for a new category of registered nurse,

¹¹ Personal paper. Memorandum from Jocelyn Peach, Secretary, NENZ, 24 May 1998.

¹² Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author, 3.

¹³ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 3.

“practicing at an advanced practice level...prepared at Master’s level of education and ...recognized and approved by the Nursing Council as a Nurse Practitioner™”.¹⁴ This new practitioner was further described:

Nurse Practitioners are unique health-care providers making independent and collaborative health-care decisions in partnership with individuals, families, and communities across a range of settings. They respond to complex situations...demonstrating leadership as consultants, educators, administrators and researchers. They actively participate in professional and legislative activities to promote professional advancement and health-related social policies....They use advanced assessment and treatment skills to manage and anticipate complex situations, administering therapies for the management of actual and potential health issues. Nurse Practitioners may or may not choose to prescribe...¹⁵

Advanced nursing practice in an international context

The term “advanced nursing practice” and the title Nurse Practitioner are not unique to New Zealand. Advanced nursing practice is an international movement that began to develop momentum in New Zealand in the 1990s. An estimated forty countries, including the United States, Canada, England, Scotland, Ireland, South Africa, and Australia have emergent or established advanced nursing practice roles.¹⁶

¹⁴ Nursing Council of New Zealand. (2001b). *The Nurse Practitioner™: Responding to health needs in New Zealand*. Wellington: Nursing Council of New Zealand, 9. Prior to the passing of the Health Practitioners Competency Assurance Act 2003, and subsequent determination of nursing scopes of practice as required under the Act, the Nursing Council undertook to trademark the term, Nurse Practitioner, as noted by the symbol in the above quote. The Nursing Council comments in a footnote on page 10 of the above publication that “the title Nurse Practitioner will be protected by the Nursing Council and will only be able to be used by those who succeed in meeting Council requirements.” The use of trademarking conveyed not only the significance and exclusivity of the title, it also conveyed a nod to the language of the market.

¹⁵ Nursing Council of New Zealand, 2001b, 12-13.

¹⁶ International Council of Nurses. (2003a). *ICN International Nurse Practitioner/Advanced practice nursing network*. http://www.icn.ch/networks_ap.htm. Accessed 25 May 2003. International Council of Nurses. (2003b). *Nurse Practitioner/Advanced practice network: Network history*. <http://www.icn.ch/apnetwork.org>. Accessed 5 December 2004.

The International Council of Nurses (ICN) defines the Nurse Practitioner/Advanced Practice Nurse (NP/APN) as

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.¹⁷

The characteristics of the NP/APN as discussed by the ICN include practice which includes advanced patient assessment and diagnostic reasoning skills, case management or own case load, regulatory mechanisms which provide for diagnostic and prescriptive authority, and a formal system of licensure or credentialing.

This contemporary nursing movement is historically associated with the development of nursing specialists – and with both a deepening of nursing knowledge, and an expansion of nursing practice. The concept of advanced nursing practice began to emerge in the United States in the 1960s, in association with the growth of the clinical nurse specialist (CNS).¹⁸ Frances Reiter is credited with being an early protagonist for advanced nursing practice because her ideas on the “nurse clinician”- a term she coined in the 1940s– were to evolve as the CNS.¹⁹ Throughout the 1970s and 1980s, as the role became associated with postgraduate level study and clinical practice in a specialty area of nursing, a range of studies provided evidence of the positive impact

¹⁷ International Council of Nurses. (2003a). *ICN International Nurse Practitioner/Advanced practice nursing network*. http://www.icn.ch/networks_ap.htm. Accessed 25 May 2003.

¹⁸ Bigbee, J. (1996). History and evolution of advanced nursing practice. In Hamric, A. Spross, J. & Hanson, C. *Advanced nursing practice: An integrative approach*. (pp.3-24). Philadelphia: W.B. Saunders Company.
Albarran, J & Fulbrook, P. (1998). Advanced nursing practice: An historical perspective. In G. Rolfe & P. Fulbrook *Advanced nursing practice*. (pp.11-32). Oxford: Butterworth Heinemann.
Dunn, L. (1997). A literature review of advanced clinical nursing practice in the United States of America. *Journal of Advanced Nursing*, 25, 814-819.
Rasch, R. & Frauman, A. (1996). Advanced practice nursing: Conceptual issues. *Journal of Professional Nursing*, 12(3), 141-146.

¹⁹ Albarran, J & Fulbrook, P. (1998). Advanced nursing practice: An historical perspective. In G. Rolfe & P. Fulbrook *Advanced nursing practice*. (pp.11-32). Oxford: Butterworth Heinemann, 14.

of the CNS on patient outcomes.²⁰ In addition to benefits to direct patient care, other roles of the CNS which became core to the notion of advanced nursing practice included leadership in education, consultation and research.

While the CNS traditionally practiced in an institutional setting, Nurse Practitioners (NP) were seen as primary care providers in the community or in hospital-based “urgency” care. “The original impetus for the development of the NP role was a shortage of physicians, especially in underserved areas and in the care of poor people”.²¹ Nurse educator Loretta Ford, and physician Henry Silver developed the first NP programme, designed to prepare pediatric nurse practitioners, in 1965.²² Over the last thirty-five years, numerous studies of NP practice have demonstrated that not only may 50-90 percent of the activities performed by physicians be safely and effectively carried out by NPs, many other benefits accrue.²³ These include features such as improved symptom relief; enhanced patient knowledge and compliance; improved continuity of care; patients more satisfied with NP care and interpersonal skills; and services “comparable to physicians’ services at lower cost.”²⁴

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- ²⁰ Haddock, K.S. (1997). Clinical nurse specialists: The third generation. In S. Moorhead, ed. *Nursing roles: Evolving or recycled?* Thousand Oaks: Sage.
Girouard, S. (1978). The role of clinical nurse specialist as change agent: An experiment in preoperative teaching. *International Journal of Nursing Studies*, 15, 57-65.
Wolf, G.A. (1990). Clinical nurse specialists: The second generation. *Journal of Nursing Administration*, 20(5), 7-8.
- ²¹ Rasch, R. & Frauman, A. (1996). Advanced practice nursing: Conceptual issues. *Journal of Professional Nursing*, 12(3), 142.
- ²² Sherwood, G. D., Brown, M., Fay, V. & Wardell, D. (1997). Defining nurse practitioner scope of practice: Expanding primary care services. *The Internet Journal of Advanced Nursing Practice*, 1(2): [http:// www. Ispub.com/journals/IJANP/Vol11No2/scope.htm](http://www.Ispub.com/journals/IJANP/Vol11No2/scope.htm) . Accessed 23 September 1999.
McGrath, S. (1990). The cost-effectiveness of nurse practitioners. *Nurse Practitioner* 15(7). 40-42.
- ²³ Girouard, S. (1996). Evaluating advanced nursing practice. In A. Hamric, J. Spross & C. Hanson. *Advanced nursing practice: An integrative approach*. (pp.569-600). Philadelphia: W.B. Saunders Company.
McGrath, 1990, 40.
Munding, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., Friedewald, W.T., Siu, A.L., & Shelansky, M.L. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomised trial. *Journal of the American Medical Association*, 283(1),59-68.
Shamian, J. (1997). How nursing contributes towards quality and cost-effective health care. *International Nursing Review*, 44(3), 79-84, 90.
- ²⁴ Shamian, 1997, 80.

As advanced nursing practice matured in the United States, including the blending of Clinical Nurse Specialist and Nurse Practitioner roles, the concept of advanced nursing practice began to take hold in the United Kingdom, Australia and New Zealand.²⁵ While they are defined in differing ways, and practitioners may have different levels of educational qualifications, key features in these roles include a focus on clinical practice, and higher levels of knowledge, skill and expertise.

National and international literature suggest that changes in nursing practice, including the evolution of new roles, develop in response to demands and changes within society.²⁶ However, this succinct explanation obscures the complex interplay of intra- and inter-professional forces, and socio-political and economic factors that impede or facilitate change. It tells us nothing about how such change is brought about. What were the driving forces that brought about the development of this new category of nurse in New Zealand?

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- ²⁵ Cronenwett, L. R. (1995). Molding the future of advanced practice nursing. *Nursing Outlook*, 43(3), 112-118.
- Dowling, S., Barrett, S. & West, R. (1995). With nurse practitioners, who needs house officers? *British Medical Journal*, 311 (29 July): <http://www.bmj.com/cgi/content/full/311/7000/309>. Accessed 17 July 2000.
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- Nurse Practitioner Project, Department of Human Services. (1999). *Victorian Nurse Practitioner Bulletin*, August. Melbourne: Author.
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- Offredy, M. (2000). Advanced nursing practice: The case of nurse practitioners in three Australian states. *Journal of Advanced Nursing*, 32(2), 274-281.
- Woods, L.P. (1999). The contingent nature of advanced nursing practice. *Journal of Advanced Nursing*, 30(1), 121-128.
- ²⁶ Carpenter, H. (1971). *World Health Organisation assignment report*. Wellington: Government Printer, 7-8.
- Patterson & Haddad, 1992 cited in Dunn, L. (1997). A literature review of advanced clinical nursing practice in the United States of America. *Journal of Advanced Nursing*, 25, 814.
- Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial taskforce on nursing: Releasing the potential of nursing*. Wellington: Ministry of Health.
- Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century*. San Francisco: UCSF Center for the Health Professions.

Research intentions

This thesis critically examines contemporary New Zealand nursing history to elucidate the forces and voices influencing the development of advanced nursing practice from the 1990s to the present. However, an understanding of the emergence of advanced nursing practice is limited without an interrogation of its antecedents. “Contemporary practices are historically embedded”²⁷ - rooted in what happened in the past, or in people’s understandings of what had happened.²⁸ “The past is never fully gone. It is absorbed into the present and the future. It stays to shape what we are and what we do.”²⁹

In interrogating “advanced nursing practice”, nursing refers to the registered nurse.³⁰ Following the Nurses Registration Act of 1901, in 1904 midwives gained statutory registration in New Zealand.³¹ However, in 1925, the separate acts for nurses and midwives were combined in a new Nurses and Midwives Act, and over the next decades, midwives increasingly came under the control and influence of nurses and doctors.³² By the late 1950s, in order to become a registered midwife, one had to also be registered as a nurse.³³ In 1990 it became possible to become a midwife without first being a nurse, and in New Zealand,³⁴ midwifery is now considered a separate

²⁷ Tuchman, G. (1994). Historical social science: Methodologies, methods and meanings. In N.K. Denzin & Y.S. Lincoln, eds. *Handbook of qualitative research*. (pp. 306-323). Thousand Oaks: Sage Publications, Inc., 310.

²⁸ Marwick, A. (1971). *Basic problems of writing history*. Bletchley: Open University Press, 12.

²⁹ Deane, in Godden, J. & Forsyth, S. (2003). Historical methods. In Z. Schneider, D. Elliott, G. LoBiondo-Wood, & J. Haber. *Nursing research: Methods, critical appraisal and utilization*. (pp.154 –162). Sydney: Mosby, 155.

³⁰ In New Zealand, there is a “second level” nurse, titled enrolled nurse (those educated prior to 2000), and nurse assistant from 2001) previously known as the community nurse, then registered community nurse. The enrolled nurse/nurse assistant “works under the direction and supervision of registered nurses or medical practitioners”. Nursing Council of New Zealand. (2003). *Enrolled nurse education framework, 2*.
Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 62.

³¹ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 87.

³² Papps, E. & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: A Foucauldian perspective*. Palmerston North: Dunmore Press, 125-126.

³³ Papps and Olssen, 126.

³⁴ 1990 Nurses Amendment Act.

profession from nursing. This thesis then, focuses on nursing, rather than the profession of midwifery.

Beginning with the question, “what are the forces influencing the meaning of the concept, and the development of advanced nursing practice in New Zealand?”, three aims were initially derived. These were to

- 1) discern the various understandings of the concept of advanced nursing practice, historically and currently, among key players;
- 2) discover why there has been a momentum toward what is termed advanced nursing practice; and to critically analyse the professional and sectoral forces influencing the development of advanced nursing practice in New Zealand in the 1990s; and to
- 3) describe and critically analyse the discourse of those key individuals shaping the development of advanced nursing practice in New Zealand.

In the process of my research, it became clear that while the discourse of key individuals shaping the development of advanced nursing practice was important, it was only one element in a complex constellation of factors. From my analysis of this array of factors and forces, I determined that they were related to concepts of professions and professionalism, professional agenda-setting, politics and political sophistication. Each of these larger concepts I found to be present not only in the development of advanced nursing practice, but at work in every juncture in which nursing has tried to advance an agenda.

Therefore, I revised the third aim of my research in order to draw together these larger concepts. This led me to deeper exploration across the disciplines of sociology, political science, and policy analysis; and to an exploration of New Zealand nursing’s professional project. This framework, and the underlying theoretical perspectives are explicated in Chapter Two.

Method, sources and ethics

This project was originally envisioned as historical research, which would also include knowledgeable-informant interviews, and discourse analysis. As Morse notes, such mixed method design is often a “standard part in each of the major qualitative research designs.”³⁵ However, the broad aims of the research, particularly the aim “to discover why there has been a momentum toward what is termed advanced nursing practice; and to critically analyse the professional and sectoral forces influencing the development of advanced nursing practice in New Zealand in the 1990s” pointed to other inductive approaches such as policy analysis. Thus, the project developed into a more complex multiple method approach.³⁶ Tashakkori and Teddlie argue that mixed methods research is particularly appropriate for studying complex social phenomena because it has the potential to enable both, a greater diversity of voices and perspectives, and more dynamic, robust explanations of the social processes being examined.³⁷

This research ultimately drew on historical, semi-structured interview/oral history, sociological and political analysis methods. Given the sweep of time being examined, and the methods I considered most appropriate to address the question, the original intent for discourse analysis was largely set aside. Nevertheless, as language has social and political implications – it can construct objects, events and versions of the social and natural world³⁸ – this thesis also explores some of these constructions.

Overall, the thesis sits within the late 20th century understanding of historical sociology.³⁹ Historical sociological studies focus on active processes over time,

³⁵ Morse, J. (2003). Principles of mixed methods and multimethod research design. In A. Tashakkori & C. Teddlie, (Ed). *Handbook of mixed methods in social and behavioral research*. (pp. 189-208). Thousand Oaks: Sage Publications.

³⁶ Tashakkori, A. & Teddlie, C., (Ed.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks: Sage Publications.

³⁷ Tashakkori & Teddlie, 2003, 14-17.

³⁸ Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage Publications, 1-6.

³⁹ Green, A. & Troup, K. (1999). *The houses of history: A critical reader in twentieth-century history and theory*. Manchester: Manchester University Press, 110.

accounting for outcomes. According to Theda Skocpol, historical sociological studies share some or all of the following characteristics:

Most basically, they ask questions about social structures or processes understood to be concretely situated in time and space. Second, they address processes over time, and take temporal sequences seriously in accounting for outcomes. Third, most historical analyses attend to the interplay of meaningful actions and structural contexts in order to make sense of the unfolding of unintended as well as intended outcomes....Finally (they) highlight the particular and varying features of specific kinds of social structures and patterns of change....For (historical sociologists) the world's past is not seen as a unified developmental story or as a set of standardized sequences. Instead it is understood that groups or organizations have chosen, or stumbled into, varying paths in the past. Earlier "choices" in turn, both limit and open up alternative possibilities for further change, leading toward no predetermined end.⁴⁰

The methods employed, the findings and the analysis and interpretation of the findings, drawing on sociology, political science and policy analysis situate this thesis as historical sociology.

Archival materials, government documents, texts, and other primary materials were used to explore meanings of "advanced nursing" in New Zealand over time, and to examine forces and voices influencing the development of nursing. In particular, Archives New Zealand [previously titled the National Archives (NA)] was a key resource. The Archives' SANS series (School for Advanced Nursing Studies, previously the Postgraduate School for Nurses) provided primary materials through which understandings of the context and meanings of advanced education for nurses could be developed. The Department of Health files held in Archives New Zealand also contain extensive material relevant to this study. Both these archives reflect the interwoven relationships between the Division of Nursing of the Department of

⁴⁰ Skocpol, T.(1984). Sociology's historical imagination. In T. Skocpol (Ed.). *Vision and method in historical sociology*. (pp.1-21). Cambridge: Cambridge University Press, 1-2.

Health, the Postgraduate School for Nurses, the Nursing and Midwives Board/Nursing Council, and the Trained Nurses' Association. A range of similarly useful material was located in the Alexander Turnbull Library, e.g. the *Report on Nursing Education in New Zealand*⁴¹ and correspondence between various committees of the New Zealand Nurses' Association and the Director of the Division of Nursing in the Department of Health. The Annual Reports to Parliament in the *Appendices to the Journal of the House of Representatives* (AJHR) were invaluable sources of data.

Extensive use has been made of the New Zealand nursing journal *Kai Tiaki*.⁴² Published since 1908, *Kai Tiaki* features national and international nursing news, editorials, letters and articles. Established by Hester Maclean, founder of the New Zealand Trained Nurses' Association (NZTNA), *Kai Tiaki* remains the official voice of the association, now the New Zealand Nurses' Organisation (NZNO). As the official journal of the NZNO, *Kai Tiaki's* news, editorials, and articles authored by its staff provide an evident bias towards the views of the organisation's executive. As only members of NZNO and libraries may subscribe to the journal, this potentially limits the range of letters to the editor and unsolicited manuscripts.

Early in this project, one of my approaches was to develop a chronology chart. This came to span from 1860 to 2005, noting key facts relating to nursing's professional organisation(s), its statutory body, pre- and post-registration education, government structure with regard to nursing, and other broader contextual notes.⁴³ This was an invaluable aid to discerning relationships across organisations and the multiple roles of many nursing figures. It also highlighted clues to socio-political circumstances of the decades.

⁴¹ Reid, A. (1965). *Report on nursing education in New Zealand*. Wellington: Whitcombe and Tombs, Ltd.

⁴² Over the years, this journal has had other titles, such as the *Journal of the Nurses of New Zealand*, the *New Zealand Nursing Journal* and *Nursing New Zealand*. However, *Kai Tiaki* has consistently been the additional title used, the traditional title favoured by New Zealand nurses, and the one used throughout this thesis.

⁴³ New Zealand nursing chronology. See Appendix Two.

“Knowledgeable-informant” interviews

Interviews were carried out with several key players or “knowledgeable informants - historical figures who have been in a position to gather reliable information”.⁴⁴

Ethical approval for the semi-structured, tape-recorded interviews was sought and obtained from the Massey University Human Ethics Committee.⁴⁵

I initiated contact with potential participants by mailing them a cover letter, an information sheet, and consent form.⁴⁶ Generally I telephoned potential participants within one week of sending the initial letter, although, in some cases they contacted me within a few days of receiving my letter.

Potential interviewees were informed that their participation was voluntary, and that they could withdraw any time during the study. Should a participant decide to withdraw during the study, s/he would have the opportunity to have tapes and/or any notes of the interview returned.

Confidentiality of the tapes, any notes taken during the interview, the transcripts, and electronic storage of the data was assured, explaining that access to that data was confined to the researcher, supervisors and the audiotape transcriber. The transcriber signed a confidentiality agreement. It was explained that the consent forms, tapes, and transcripts would be kept in a locked place.

Each potential participant was offered the choice for her own name to be used in regard to attributing opinions and information. Should she not wish to have her name used, a description of her relevant role in nursing would be used, and it was pointed out that, given the nature of participants’ roles, one’s identity might readily be discerned by readers of the research. Based on these understandings, potential

⁴⁴ Tuchman, G. (1994). Historical social science: Methodologies, methods and meanings. In N.K. Denzin & Y.S. Lincoln, eds. *Handbook of qualitative research*. (pp. 306-323). Thousand Oaks: Sage Publications, Inc., 311.

⁴⁵ Letter to Susan H. Jacobs, copied to Professor Julie Boddy and Associate Professor Margaret Tennant from Professor Philip Dewe, Chairperson, Massey University Human Ethics Committee, dated 15 November 1999. See Appendix One.

⁴⁶ See Appendix One.

participants could choose whether to be interviewed. Consent was obtained for this study and for any publications or presentations arising from it. With regard to the use of the participant's name, a separate consent statement was provided, and participants could make this decision following review of the transcript.

Participants were sent two copies of the transcribed interview in order that they could correct any inaccuracies, to add to any comments, and to retain a copy for themselves. They were also offered a copy of the tape-recording.

Ten nurses were interviewed. They were purposefully selected, based on the criteria that they had been in strategic positions in organisations pivotal to nursing and/or during eras of significant initiatives and change in New Zealand nursing. In some cases, potential participants were obtained by snowball sampling. Participants' experiences in nursing span over a seventy-year period - from the 1930s through 2002.

A prominent link was the New Zealand School for Advanced Nursing Studies. Known as the Postgraduate School for Nurses from its opening in 1928, it became the New Zealand School for Advanced Nursing Studies (SANS) in 1970.⁴⁷ SANS was a key connection, not only as suggested by its name, but because for over forty-five years – from 1928 to 1973 - it was the only educational institution in New Zealand offering further study in nursing for registered nurses. Thus past students and teachers of the school were often to later hold positions of responsibility in nursing services, the Department of Health, the Nursing Council of New Zealand, and the New Zealand Nurses' Association.

Interviews clarified how the social and professional world seemed to some of its central players at various points in time, provided valuable first-hand data, and helped to illuminate contextual and recurrent forces. However, oral history may be considered “an example of a source straddling the distinction between primary and

⁴⁷ NA, H, W2191, 1/23/2 pt 1 (40390), bx 48, Nursing, NZSANS Advisory Committee 1968-1973.

secondary sources.”⁴⁸ The most serious criticism of oral evidence is that memory is “unreliable, subjective, and frequently unverifiable.”⁴⁹ However, these criticisms may be addressed.

With regard to the concern for unreliability of memory, older interviewees for this thesis were recalling from their long-term memory - events from many years ago, and from formative or important phases of their careers – memories which are more likely to be accurate.⁵⁰ Following the interviews, several older interviewees took pains to send me hand-written notes of brief chronologies relevant to their career and our discussions. They also checked the transcription of the interviews, occasionally correcting names and adding dates. In these cases, where the memory of older knowledgeable-informants could be considered less reliable – recalling specific dates or exact chronology of events, meetings or discussions – data regarding these events was able to be retrieved or corroborated by archival sources. Aspects of oral history data which were not verifiable were determined to fit within the wider context. While oral history occasionally provides a singular point of evidence, usually it “complements the documentary evidence, providing material which may not be available in written records.”⁵¹

The subjectivity of oral history is a particular reason for engaging in the interview. The researcher attempts to understand the experiences, perceptions, and interviewee’s conception of his/her lived world. While there are constructive dimensions of remembering, oral evidence nevertheless enables the linking of “remembered experience with the broader economic and political currents of history.”⁵²

⁴⁸ Godden, J. & Forsythe, S. (2003). Historical methods. In Z. Schneider, D. Elliott, G. LoBiondo-Wood & J. Haber. *Nursing research: Methods, critical appraisal and utilization*. (pp.154-162). Sydney: Mosby, 158.

⁴⁹ Green, A. (2004). Oral history and history. In A. Green & M. Hutching, (Ed.). *Remembering: Writing oral history*. (pp. 1-8). Auckland: Auckland University Press.

⁵⁰ Hutching, M. (1993). *Talking history*. Wellington: Bridget Williams Books in association with the Historical Branch, Department of Internal Affairs 57-60.

⁵¹ Hutching, 1993, 58.

⁵² Green, 2004, 3.

As a memory “trigger” for the interviewee, and to assist my own focus, I developed three loose interview question guides including reminders for me to “re-state – seek clarification”, etc. One guide was for use with knowledgeable-informants who were involved with the School for Advanced Nursing Studies or that period; another was for persons involved in the Advanced Diploma in Nursing or that era; and the third was for key players of the 1990s. Only the first and last of the three interview guides were required, and for the most part, served as reminders for me should interviewees seem to stray far off the topic. All of the interviews except one took place in the interviewee’s home or office. One interview took place in a small interview room at my place of work, as suggested by the interviewee who was planning a visit to my region.

I knew four of the ten “knowledgeable-informants” personally to a slight degree through the nursing community. In all of the interviews I felt a sense of warmth, eagerness to share, and candidness. However, upon reviewing the transcript of one interview, I realized that while the interviewee had seemed quite relaxed, she actually had been guarded. Only upon reading the transcript did I appreciate that some of her responses were wordy and vague, and I had not probed as well as I might have. However, I determined that a further interview with her was not required, as there were substantial primary sources to clarify and/or corroborate her statements.

Interviews were audio-taped and transcribed. All participants generously gave consent for their names to be used. Following is a brief overview of the interview participants:

Alice Reid Fieldhouse was an instructor at the Postgraduate School for Nurses/School for Advanced Nursing Studies from 1948 –1955, and again from 1968 – 1972. Alice’s long career in nursing provided a broad perspective, from the depression through the end of the 1970s.

Alice’s background prior to her entering nursing also provided her with a particular perspective on her nursing education and her later practice as a nurse educator. She had studied mathematics, sciences, and languages at Auckland University, but did not complete her degree at that time, choosing to

enter nursing. Following completion of her general nursing training in 1937, and practice as a staff nurse, she also completed maternity and Plunket (child health) training programmes. In 1941, Alice completed her diploma through the Postgraduate School for Nurses and then taught at the Auckland Hospital School of Nursing for two years. Following World War II, she worked with displaced persons in Germany for the United Nations. This preceded her first period of teaching at SANS. Alice had other overseas experiences including study, professional visits, and work for the World Health Organisation. She was awarded a Commonwealth Fund (Harkness) Fellowship for 1951-52, which permitted her to complete her M.A. at Columbia University in New York. Following the closure of SANS, Alice taught part-time in the newly established nursing section of the Victoria University of Wellington. Alice is a recipient of a Queen's Service Medal.

Shirley Lowe Bohm was the Director of the Division of Nursing, Department of Health from 1966 to 1978. She had been Assistant Director from 1964-1966. In the capacity of Director, she was also the Registrar of the Nursing Council of New Zealand until the 1971 Nurses Act which established the Nursing Council as a corporate body. During Shirley's tenure in the Division of Nursing, she facilitated the work of two overseas nursing academics invited to New Zealand to provide reports regarding New Zealand nursing education. These were Alma Reid in 1965,⁵³ and Dr. Helen Carpenter in 1970.⁵⁴ Shirley was also instrumental in significant changes in the structure of the Division, the Nurses' and Midwives' Board/Nursing Council, and SANS; and relationships between the Division of Nursing and the New Zealand Nurses' Association. She was named member of the Order of the British Empire (OBE) for services to nursing.

Shirley qualified as a registered nurse in 1948, and in 1949 completed a maternity nursing programme. She attended SANS, and was taught by Alice

⁵³ Reid, A. (1965). *Report on nursing education in New Zealand*. Wellington: Whitcombe and Tombs, Ltd.

⁵⁴ Carpenter, H. (1971). *World Health Organisation assignment report*. Wellington: Government Printer.

Fieldhouse, who Shirley described as “just a wonderful person with a very clear idea of where we should be going and what should be happening.”⁵⁵

Prior to her appointment as Director, Shirley had been a Principal Nurse; Principal Tutor in a general nursing programme; Nurse Advisor in the Department of Health; was involved in the establishment of a research unit within the Department; and then Assistant Director, Division of Nursing.

Elsie Boyd was the Assistant Director of Nursing, Nursing Education, in the Department of Health from 1967 – 1980. She had also been an instructor at SANS from 1964-1965.

Following general nurse training in 1944, Elsie completed maternity nurse training, practiced in surgical and theatre nursing, and then was appointed as a tutor in the Auckland Hospital School of Nursing in 1950. Elsie completed a SANS diploma in nursing education in 1952, and returned to her position at the Auckland School of Nursing. Elsie was awarded a Commonwealth Fund Scholarship for overseas study in 1955, and a World Health Organization Traveling Fellowship in 1966.

Dr. Nan Kinross worked with Shirley Bohm and Elsie Boyd in the Division of Nursing, from 1967- 1973, when she was also an Assistant Director. Nan had completed general nursing training in 1952 and followed this with maternity training in 1953. She attended SANS in 1956.

Awarded a British Commonwealth Scholarship, Fulbright travel grant and Rockefeller Foundation Fellowship, Nan undertook a study tour of the USA and Canada, completing her M.A. in nursing at the University of California, Berkley in 1961. She was Supervising Matron of Southland Hospital from 1962 until her appointment to the Division of Nursing. Nan subsequently was a nursing lecturer (1973-82), then Professor and Head of Department, Nursing at Massey University. She completed her doctorate through Massey University in 1981. Nan was an active member in the New Zealand Nurses’

⁵⁵ Interview with S. Bohm, 25 March 2000.

Association, holding a range of roles including member of the National Executive Committee, representing NZNA at the International Council of Nurses Congresses in 1965, 1969, and 1981.⁵⁶

Dame Margaret Bazley has also had a long and distinguished career in nursing, which was followed by an equally distinguished career in the wider state sector. She was President of the New Zealand Nurses' Association from 1972- 1974, and was a key figure in the political efforts to ensure the transfer of nursing education into the tertiary education system.

Margaret completed psychiatric nursing training in 1959, followed by general nursing in 1961. She was a Charge Nurse at Tokanui Psychiatric Hospital, and then Assistant Matron at the Seacliff Group of Hospitals. Following completion of a SANS diploma, Margaret was Matron of Sunnyside Hospital from 1965 – 1973. She subsequently worked in public health nursing, and held positions as Deputy Matron at the Auckland Hospital Board, and Chief Nursing Officer, Waikato Hospital Board. Margaret was the Director, Division of Nursing from 1978 – 1984. In 1984 she was appointed State Services Commissioner, the first woman to hold this post.⁵⁷ She has held positions of Chief Executive, Department of Work and Income; Chief Executive, Ministry of Social Policy; Director-General, Social Welfare; Chairperson, New Zealand Fire Service; Chairperson, Foundation for Research, Science and Technology, and member of the Waitangi Tribunal.⁵⁸ In 1999 she was named Dame Companion of the New Zealand Order of Merit.

Janice Wenn initially qualified as a registered general nurse in 1955. She later completed midwifery training in Australia, where she worked as a “bush nurse”. After returning to New Zealand, Janice completed a short course in public health nursing at SANS in 1967, and then a diploma there in 1969. She

⁵⁶ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 195.

⁵⁷ McLoughlin, D. (2001, 29 September). A passionate woman. *The Dominion*, 2.

⁵⁸ The Waitangi Tribunal Members. Retrieved 13 August 2005 from <http://www.waitangi-tribunal.govt.nz/about/waitangitribunal/wtme>

was a SANS instructor from 1972- 1976. During the period that Janice was an instructor at SANS, nursing education began to move from the hospital-based apprentice programmes to diploma programmes in the tertiary education system. It was also during this time that the first post-registration degree programmes in nursing were established at Massey and Victoria universities. SANS closed in 1979.

Janice's experiences and perspectives as a student and then an instructor at SANS during the campaign for improvements to the system of nursing education and the eventual establishment of the first polytechnic and university programmes provides a useful window on those periods. Janice has held positions of Nurse Inspector for the Department of Health, Principal Nurse, Chief Nurse, and has served on the Nursing Council. In 2000, she was appointed to the New Zealand Order of Merit for services to nursing and the community.

Judy Kilpatrick was Chairperson of the Nursing Council of New Zealand from May 1996 to April 2002. It was during this period that the Nursing Council developed a number of documents relating to post-registration nursing education, nurse-prescribing and advanced nursing practice, and appointed the first Nurse Practitioner. Judy was also a member of the Ministerial Taskforce on Nursing which sat during 1998, and was appointed as the Nursing Council representative on the New Prescribers' Advisory Committee which held its first meeting 31 July 2001.⁵⁹

Judy qualified as a registered general and obstetric nurse in 1970. She has been a nurse educator in a hospital school of nursing, and later at the Auckland Institute of Technology (AIT), (now Auckland University of Technology). She was Head of School of Nursing and Midwifery at AIT from 1991 to 1999, when she moved to the University of Auckland to establish nursing

⁵⁹ Minutes of the First Meeting of the New Prescribers Advisory Committee (NPAC), held 31 July 2001. Retrieved 6 January 2004 from <http://www.newhealth.govt.nz/npac/minutes/310701.htm>

programmes there. In 1998 Judy was named Companion to the New Zealand Order of Merit.

Dr. Frances Hughes was the Chief Nursing Advisor in the Ministry of Health, 1997 until late 2004. She was appointed as a senior nurse advisor in the Ministry in June 1996. Frances became acting chief advisor in June 1997, and was formally appointed as Chief Nursing Advisor in December 1997.

Frances began her nursing career after completing a general and obstetric nursing programme at Hutt Hospital in 1976. In 1983, Frances completed a psychiatric nursing programme. Frances has been a nurse educator, held senior clinical positions, and in 1993, was the founding president of the New Zealand branch of the Australia and New Zealand College of Mental Health Nurses. Frances is an accredited New Zealand Nurses Organisation Nurse Clinician, a Fellow of the College of Nurses Aotearoa, New Zealand, and a Commandant-Colonel of the Royal New Zealand Army Nursing Corps.⁶⁰

Frances was also a member of the Ministerial Taskforce on Nursing. Frances was awarded a Harkness Fellowship in Health Care Policy, studying at the University of Pennsylvania Center for Health Outcomes and Policy Research in 2002. She completed her doctorate in 2003. In 2005 Frances was appointed as Officer of the New Zealand Order of Merit.

Dr. Denise Dignam is a nursing academic. She has been a nursing lecturer at Massey University, Head of the Faculty of Health Sciences at Unitec Institute of Technology, and Associate Professor at Massey University. Her perspective was sought because of her membership on the 1997 Ministry of Health working group which examined safety and quality issues in relation to potential extension of prescribing rights to nurses; her subsequent membership on the Ministry's child and family health nurse-prescribing working group (1998), and her appointment to the New Prescribers' Advisory Committee.

⁶⁰ Ministry of Health: About: The Chief Advisors. Retrieved 6 January 2004 from <http://www.moh.govt.nz/moh.nsf/>

Dr. Jenny Carryer has been a prominent figure in New Zealand nursing since the early 1990s. She has a joint appointment as Professor/Clinical Chair of Nursing with Massey University and MidCentral Health District Health Board. In 2000 Jenny was appointed Member of the New Zealand Order of Merit.

Her perspective was sought primarily because of her involvement in the Ministerial Taskforce on Nursing, and because of her role as foundation President/Executive Director of the College of Nurses Aotearoa, New Zealand from 1992-current. The College had convened a Consensus Conference/Workshop on Advanced Nursing Practice in March 1999 with invited scholar, Dr. Sarah Sheets-Cook of Columbia University. The goal of the conference was “to develop guidelines which will underpin the development of advanced practice roles for New Zealand nurses.”⁶¹

Three other people were sought or considered for interview. However, they were either unwell, did not respond to the initial contact by mail, and/or were unable to be contacted. Other people might have been approached. However it was felt that the data gained from those interviewed, given their range of experience and involvement with particular eras and/or key events, provided sufficient coverage, particularly when supplemented by other primary sources.

⁶¹ College of Nurses, Aotearoa, New Zealand. (1999). *Emerging guidelines for advanced practice nursing in New Zealand from the advanced practice workshop*, Palmerston North, 1-3 March. Palmerston North: Author.



Miss A. M. Reid

Alice (Reid) Fieldhouse, 1955.
With permission of *Kai Tiaki*



Alice Fieldhouse, 2001
With permission, *New Zealand Nursing Review*



Shirley (Lowe) Bohm, 1979
Courtesy of Shirley Bohm



Miss E. A. Boyd

Elsie Boyd, 1955
With permission, *Kai Tiaki*



Dr. Nan Kinross, 1989
With permission, *Kai Tiaki*



Dame Margaret Bazley, 2001
With permission, *The Dominion*



Janice Wenn
Courtesy of Janice Wenn



Judy Kilpatrick, 2001
With permission, *New Zealand Nursing Review*



Dr. Frances Hughes, 1998
With permission, *Kai Tiaki*



Dr. Denise Dignam, 2002
With permission, *New Zealand Nursing Review*



Dr. Jenny Carryer, 2000
With permission, *New Zealand Nursing Review*

Personal nursing history

I include an overview of my background, and my career in nursing, as a reflexive tool, and to situate me as a practitioner within this sociological interpretive history. This provides another text for consideration in critical analysis of this work and my other narratives regarding advanced nursing practice.⁶²

I immigrated to New Zealand with my family from the United States in 1986, having been appointed to the position of Associate Head of School of Nursing at the Hawke's Bay Community College [renamed the Hawke's Bay Polytechnic, then Eastern Institute of Technology(EIT)]. I later became Dean of the Faculty of Health and Sport Science at EIT. My nursing education and experience as a clinician and as an educator had been quite different from that of my New Zealand colleagues, but in many ways, I found nursing was a universal language.

I had originally completed what was at the time a very new type of nursing programme—a community college associate degree in nursing, and then transferred to Florida State University to complete a Bachelor of Science (Nursing) degree. Later, when my husband went to Auburn University, I was eager to pursue postgraduate study as well. Auburn University did not have a nursing faculty, so I explored study possibilities in physiology. I was able to secure a full scholarship for a master's degree programme to prepare people for teaching. The programme was designed to develop “discipline expertise”, with emphasis on discipline-related coursework, and two tertiary education courses, including a teaching practicum. I completed a Master of Arts with a major in physiology, and minors in biochemistry and tertiary education.

⁶² Jacobs, S. (2003a). Advanced nursing practice: Time and meaning. *Nursing Praxis in New Zealand*, 19(3), 29-39.
Jacobs, S. (2003b). Courage under fire: The transfer of nursing education from apprenticeship to tertiary education. *Nursing Review*, October, 15-17.
Jacobs, S. (2001). Educating nurses: A history of New Zealand nursing education. *Nursing New Zealand Centenary Souvenir: 1901-2001*, 42-43.
Jacobs, S. (2000). Credentialing: Setting standards for advanced nursing practice. *Nursing Praxis in New Zealand*, 16(2), 38-46.
Jacobs, S. (1999). Advanced nursing practice: Refining a New Zealand approach. *VISION: A Journal of Nursing*, 5(8), 24-26.
Jacobs, S. (1998). Advanced nursing practice in New Zealand: 1998. *Nursing Praxis in New Zealand*, 13(3), 4-12.

Prior to our move to New Zealand, my nursing practice experience spanned critical care, community health, large and small hospitals, and metropolitan as well as rural communities. I enjoyed a joint appointment to teach nursing theory and practice for the Nursing Department, alongside teaching pathophysiology for the Life Science Department of a tertiary education institution.

My experiences in New Zealand nursing education have been enormously rich, and have spanned nearly two decades of development and change. I have enjoyed opportunities to work with national colleagues as a part of Nurse Education in the Tertiary Sector (NETS); to collaborate with colleagues in education and practice settings; and I was privileged to serve as a member of the Nursing Council of New Zealand for a brief period.

The changes of the 1990s in particular, were fraught with difficult challenges as well as exciting opportunities. Certainly the movement towards advanced nursing practice captured my interest, and has been the impetus for this study.

I am aware that as a minor leader in New Zealand nursing, I have certain biases towards leaders, and personal values relating to leadership and my profession. In particular, I have deep beliefs in the difference nursing makes in the lives of individuals, in the value of nursing for the health of a country, and in the profession's potential. As a corollary of this, I believe each nurse has an obligation to serve the profession through local and national participation in professional, health and social policy arenas. Certainly, at different times in their lives, people have different capacities and opportunities to participate, and over the years, my own involvement in nursing has waxed and waned. However I place engagement with one's professional organisation(s) and with the politics of public health and welfare as an essential thread throughout one's professional life.

My particular values and nursing experiences underlie my interest in the forces and voices influencing the advanced nursing practice movement. It also seems likely that I share values with many of the "knowledgeable-informants" of this study. While the arguments put forth in this study are based on sound evidence, inevitably, this history

is focused through my lenses. My sense in carrying out this research is captured in the reflection, “Doing history means building bridges between the past and the present, observing both banks of the river, taking an active part on both sides.”⁶³

Nursing histories

Education is a key plank in the history of any profession, and it emerged as a recurring theme in the participant interviews. The persistence and abuses of apprentice-style training of nurses, and the long struggle by the profession to achieve a “proper” education for nursing were frequently mentioned by the “knowledgeable informants” who were involved in the 1950s and 1960s. The establishment of the nursing degree as entry-to-practice, and postgraduate programmes were issues for participants from the 1980s and 1990s.

Underlying these participant dialogues were issues of gender, power, conflict, reform and professionalisation strategies. Unsurprisingly, nursing histories are replete with these issues. Several researchers have studied the New Zealand system of apprentice-style nursing education and service. Drawing on a framework for professionalism which emphasized professional knowledge, professional autonomy and a service ideal, Kim Filshie explored New Zealand nursing’s struggle for its education to be based within institutions of higher learning.⁶⁴ Filshie argued that the change from “training” in the hospital setting to “teaching” in the polytechnic setting, and the establishment of post-registration nursing studies at universities allowed nurses a level of professional status which they had never before enjoyed”.⁶⁵ However the evidence for this conclusion is not clear, and nor does Filshie offer a critique of professionalism.

⁶³ Schlink, B. (1998). *The reader*. London: Phoenix, 178. (translated from the German by Carol Brown Janeway).

⁶⁴ Filshie, K. (1985). Nursing education in New Zealand: 1960-1973- The struggle to attain professional status for the New Zealand nurse. An essay in partial fulfilment of the requirement for the degree Master of Arts in History, University of Canterbury.

⁶⁵ Filshie, 52.

Jan Rodgers examined the first fifty years of nursing education in New Zealand, and argued that the enduring influence of the Nightingale ethos trapped nursing in a pattern of “nurse equals woman”, which thus made advanced training and nursing incompatible.⁶⁶ Similarly, exploring American nursing history, Vern and Bonnie Bullough⁶⁷ and JoAnn Ashley⁶⁸ examined the persistence of the apprenticeship approach to nursing education and hospital care, and the consequences for the development of nursing. Ashley’s work demonstrates the paternalistic dominance of the hospital hierarchy and of medicine over nursing, and society’s complicity. As part of “second-wave feminism”⁶⁹ such histories were useful in explicating why nurses had been economically exploited, and thwarted in their attempts to reform their educational preparation, and to control and develop their own practice.

However, by the late 1980s and 1990s, more analytically balanced histories emerged, which recognised nursing agency and experience. Writing in the United States, Barbara Melosh,⁷⁰ Ellen Baer,⁷¹ and Susan Reverby⁷² explored the ways in which differences within nursing – particularly between the “everyday” or rank-and file nurses and the nursing leaders – was a chasm nursing failed to bridge. Christopher Maggs⁷³ and Celia Davies⁷⁴ also explored similar issues in the United Kingdom. The

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- ⁶⁶ Rodgers, J. (1985). Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. M.A. thesis, Massey University.
- ⁶⁷ Bullough, V. & Bullough, B. (1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm.
- ⁶⁸ Ashley, J. (1976). *Hospitals, paternalism, and the role of the nurse*. New York: Teachers’ College Press.
- ⁶⁹ Melchior, F. (2004). Feminist approaches to nursing history. *Western Journal of Nursing Research* 26(3), 340-355.
- ⁷⁰ Melosh, B. (1982). *The physician’s hand: work, culture and conflict in American nursing*. Philadelphia: Temple University Press.
- ⁷¹ Baer, E. (1985). Nursing’s divided house: An historical view. *Nursing Research* 34(1), 32-38.
- ⁷² Reverby, S. M. (1987a). *Ordered to care: The dilemma of American nursing, 1850-1945*. Cambridge: Cambridge University Press.
- ⁷³ Maggs, C. (1983). *Origins of general nursing*. London: Croom Helm.
Maggs, C. (ed.) (1987). *Nursing history: The state of the art*. London: Croom Helm.
- ⁷⁴ Davies, C., ed. (1981). *Rewriting nursing history*. London: Croom Helm.
Davies, C. (1995). *Gender and the professional predicament in nursing*. Buckingham: Open University Press.

differences in values, beliefs, and experience generated differing emphases on issues, prevented understanding, and resulted in alienation from each other's agendas. Thus the profession was unable to implement strategies to counter the devaluation of nursing knowledge and work, and to therefore reform its education, practice, and to shape its own future.

More recently in New Zealand, Patricia Sargison studied the three-year hospital training of the general nurse in the period 1901 to 1930, seeking to test Reverby's concept of the "dilemma of caring", exploring how the ideologies of "good woman" and "good nurse" were linked.⁷⁵ With trained nursing structured "essentially as woman's work", nurses would be expected to embody the ideal woman. It was to become a double-edged sword. The ideology of the nurse as woman meant that duty, sacrifice and fulfillment were the cornerstones of the profession. Sargison concludes:

As models of ideal womanhood, nurses achieved a great deal. They were women of considerable status and universally admired. But womanly ideologies also imposed many constraints on the development of nursing as an independent profession and these constraints continue to cause problems for nurses to this day.⁷⁶

Annette Stevenson examined general hospital nursing in New Zealand between 1945 and 1960⁷⁷ - the period following that studied by Sargison - during which the social security system was established, and nursing leaders increasingly pushed for reform of nursing education and practice. Drawing on the recollections of thirty-four nurses, Stevenson found few changes had occurred to the organisation of general hospital nursing since the 1930s. A hierarchical system of control, discipline masquerading as professionalism, and a six-day workweek continued as hallmarks of hospital nursing. The "nurses" were still primarily trainees, whose training was secondary to cleaning

⁷⁵ Sargison, P. A. (2001). "Essentially a woman's work": A history of general nursing in New Zealand, 1830-1930. Ph.D. thesis, University of Otago.

⁷⁶ Sargison, 2001, 260.

⁷⁷ Stevenson, A. F. (1997). Realities and rhetoric: General hospital nursing in New Zealand 1945 to 1960. M.A. thesis, Victoria University of Wellington.

and patient care. The hospital as the place of training was a powerful system to reinforce the requirement that every nurse/woman should know her place. These studies provide perspectives which complement and balance the recollections of nursing leaders during that formative period of New Zealand nursing's development.⁷⁸

In contrast to the studies of hospital nurses, Ann McKillop's research explored the development and practice of the Native Health Nurses in the period 1911 to 1930.⁷⁹ Working with Maori communities in rural and remote areas, in general isolation from professional colleagues and Health Department support, the Native Health Nurses "expanded the conventional boundaries of nursing practice".⁸⁰ McKillop's work describes the difficulties and often impossibilities of these nurses in maintaining a separation of the traditional roles of doctor diagnosing and prescribing, and the nurse following orders, observing and supporting. She concludes that the Native Health Nurses not only expanded the nursing role, they extended the scope of practice into health promotion and disease prevention. It seems that many of these nurses also practised in a way that would later be described as culturally sensitive or culturally safe.

Elaine Papps⁸¹ and Patricia French's⁸² research add to the understanding of the gendered construction of nursing. Papps used a Foucauldian perspective to examine the systems of nursing education, nursing curricula and the regulation of nursing, and

⁷⁸ Maclean, H.(1931). *Nursing in New Zealand: History and reminiscences*. Wellington: Tolan Printing Co.
Lambie, M.(1950). *Historical development of nursing in New Zealand*. Wellington: Department of Health.
Lambie, M. (1956). *My story: Memoirs of a New Zealand nurse*. Christchurch: N.M. Peryer Ltd.
Pengelly, E. (1956). *Nursing in peace and war*. Wellington: The Wingfield Press.
Smith, M.G. & Shadbolt, Y.T. (ed.)(1984). *Objects and outcomes: New Zealand Nurses' Association 1909-1983*. Wellington: New Zealand Nurses' Association.

⁷⁹ McKillop, A. (1998). Native health nursing in New Zealand 1911-1930: 'A new work and a new profession for women'. Thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing, Massey University.

⁸⁰ McKillop, 1998, 108.

⁸¹ Papps, E. (1997). Knowledge, power, and nursing education in New Zealand: A critical analysis of the construction of the nursing identity. Ph.D. thesis, University of Otago.

⁸² French, P. (1998). A study of the regulation of nursing in New Zealand 1901-1997. M.A. thesis, Victoria University of Wellington.

their relationship to the construction of the New Zealand nurse identity, and the relationship of social relations of power to that identity. Also employing Foucauldian discourse analysis in her historical research, Patricia French focused on the regulation of New Zealand nursing education and practice. While New Zealand nurses generally celebrate New Zealand's world-first achievement of statutory registration for nursing, French argued that the establishment of statutory registration for nurses created a framework of control. She noted the "primacy of the labour requirements"⁸³ of hospitals over the educational needs of students, and the power of the medical profession over nursing. Both of these influences were external to nursing, but were also reinforced internally. French's study dissects how patriarchy, the prevailing view of women's capabilities and place, and state control of nursing effectively limited nurses' ability to direct their own education and practice. Her work thus provides a distinctive contribution to New Zealand nursing history. My thesis, examining professional and socio-political forces from a framework of the professional project extends her work, and will assist nurses to

understand the controls that are around them, how they are limited by their own discourse and those of other groups and with that awareness begin to recognise opportunities for further research which will uncover other power/knowledge mechanisms and thus identify ways of maintaining, regaining control, or cementing control over their own practice and education.⁸⁴

Barbara Gay Williams used a hermeneutic, interpretive process to "gain meaning and understanding of the past of New Zealand nursing to reveal trends and patterns that could inform us in the present and prepare us for the future".⁸⁵ Drawing on archival sources, public documents and the oral histories of twelve nursing leaders in the period 1960-1990, Williams developed an over-arching concept of the primacy of the nurse underpinned by four themes: nurses' decision making; changes over time; an

⁸³ French, 1998, 137.

⁸⁴ French, 1998, 163.

⁸⁵ Williams, B. G. (2000). *The primacy of the nurse in New Zealand 1960s-1990s: Attitudes, beliefs, and responses over time*. Ph.D. thesis, Victoria University of Wellington.

emerging understanding of autonomy and accountability; nurses as a driving force; and creating a nursing future. Williams' research illustrates how the values, beliefs and attitudes of nurses can be powerful – or powerless - instruments to effect change at all levels. Her exploration of nurses' understanding of autonomy and accountability, and nurses as driving forces provide examples of attitudes and understandings that impinge on the development of nursing's "political sophistication", and notions of professionalism. However, while Williams contextualised the material drawn from the interviews, she did not develop a strong socio-political, or action framework.

Kathryn Adams' study of the discursive formation of professional nursing in New Zealand offers a powerful framework for understanding New Zealand nursing and the New Zealand nurse.⁸⁶ Adams argues that there have been two eras of "epistemic transformation" in New Zealand nursing. The first epistemic shift – premodernism to modernism-occurred with the establishment of Nightingale model nursing training in New Zealand. The second era – postmodernism - was initiated by the transfer of nursing education from apprentice-style training to the tertiary education system in the 1970s, followed by the establishment of the baccalaureate degree as entry-to-practice in the 1990s. Adams' Foucauldian analysis examines the social and political forces shaping nursing's struggle for status across these two eras. In examining each of her six "discursive regimes," Adams draws on the biographies of particular nurses to characterize the period of nursing's development.

In common with these nursing histories, my thesis reflects New Zealand nursing's Nightingale legacy, the social construction of woman/nurse, nursing's hierarchical control, its difficulties in the socio-political sphere, and the profession's struggle to gain control over its education and practice. However, while my study includes a similarly broad sweep in New Zealand nursing history as Papps and Adams, my examination of New Zealand nursing history is drawn from the perspective of advanced nursing practice. Furthermore, my thesis provides a case study of the forces at work in the emergence of New Zealand's version of contemporary advanced

⁸⁶ Adams, K. (2003). A postmodern/poststructural exploration of the discursive formation of professional nursing in New Zealand 1840-2000. Ph.D. thesis, Victoria University of Wellington.

nursing practice at the turn of the 21st century. It explores professionalisation, political agenda-setting, political sophistication and the professional project in a way which creates new understandings of New Zealand nursing leaders and leadership and of the professional-political dynamic. This thesis also develops a framework that has the potential to enable nursing to forge “autonomy and altruism as linked qualities”,⁸⁷ and to provide nursing with a conceptual tool to achieve its preferred future.

Overview of the thesis

The following chapters will explore New Zealand nursing history in several layers.

Chapter Two explores the theoretical perspectives of this thesis. It examines understandings regarding professions and professionalisation which until relatively recently, have remained static. Factors which contribute to a profession’s development and its ability to advance an agenda are examined. The concept of professional project is explored, and a framework for support of nursing’s professional project is presented.

Chapter Three examines the evolution of meanings and understandings of advanced nursing practice in New Zealand. Seven strands of meanings are explored in their historical and contemporary contexts.

Chapters Four, Five and Six trace the development of New Zealand nursing up to the 1990s. In detailing this history, particular attention is drawn to features of nursing’s professional project; and to the external and internal conflicts relating to nursing education – a critical foundation for advanced nursing practice. **Chapter Four** describes the period 1860 to 1960. It was during this period that the first hospital training programme for nursing was established, the New Zealand Nurses Act, the world’s first statutory nursing registration act, was passed, and New Zealand nursing achieved and then lost a university-based nursing education programme.

⁸⁷ Reverby, 1987a, 207.

Chapter Five explores New Zealand nursing's national and international networks. In particular, it describes the national assemblage of power and influence in New Zealand nursing comprised of the Director, Division of Nursing in the Department of Health, the Nurses and Midwives Board, the New Zealand Trained Nurses' Association, and the Postgraduate School for Nurses.

Chapter Six discusses the twenty-year campaign to improve nursing education, and in particular to establish some nursing education within the tertiary education system. The counter forces of vested interests - financial, power, and social order - prolonged the transformation.

Chapter Seven explores the tensions and forces of the 1990s. Beginning with the state sector reforms of the 1980s and continuing with far-reaching reform in the early 1990s, this period drastically altered the orientation and management of the state sector, including health and education, employer-employee contract relations, and the socio-economic fabric of the country. This chapter discusses the effects of these reforms on nursing. While traditional structures and leadership platforms were swept away, other opportunities were created.

Chapter Eight investigates the development of "advanced nursing practice" and the Nurse Practitioner in New Zealand. Premised in the health reforms, the establishment of a Clinical Training Agency, and a proposal to enable nurses to prescribe medications opened possibilities of new education and practice opportunities. The Ministerial Taskforce on Nursing, a divisive response from the New Zealand Nurses' Organisation and the influence of key leaders are explored.

Chapter Nine provides a summary and concludes the thesis.

Chapter 2: Theoretical Perspectives – The Professional Project and A Framework for Nursing’s Development

Time is a river which carries me along, but I am the river; it is a fire that consumes me, but I am the fire.⁸⁸

Introduction

In the process of this study, particular themes consistently reoccurred: the power of particular nursing leadership, national and international nursing networks, the development of nursing organisations, knowledge development in the discipline, perceptions of problems in the health sector, responses to perceived problems, and political agendas. My analysis of these themes pointed to the sociological concepts of profession and professionalisation, together with concerns of professional agendas, politics, and political sophistication. I found each of these themes and the larger conceptual constructs to be present not only in the development of advanced nursing practice, but at work in every juncture in which nursing has tried to advance an agenda.

Further exploration of the literature on the sociology of professions, nursing literature on professionalisation, research in political science and policy analysis led me to develop representations of nursing’s professional project and a framework of factors supporting the professional project. This chapter examines the overarching concepts and explicates my framework for nursing’s development.

Professions and professionalisation

The professions as we know them today largely evolved in the nineteenth century. At the beginning of the nineteenth century in England and the United States, the “recognised gentlemanly professions”⁸⁹ were divinity, the law and medicine. As the number of skilled occupations increased in response to the forces of industrialisation, capitalism, and democratisation, the developing middle classes embraced the ideology

⁸⁸ Borges, cited in SA Perspectives, *Scientific American*, Special Issue, September 2002, 4.

⁸⁹ Larson, M. (1977). *The rise of professionalism*. Berkeley: University of California Press, 4.

of professionalism, and the possibility of a professional career as a means of “gaining status through work”.⁹⁰ This transformation of the structure and character of European and Anglo-Saxon societies was “dominated by the reorganization of economy and society based on the market.”⁹¹

The determination of a “profession” relied for many years on sets of criteria, which were largely promulgated by the professions themselves.⁹² Thus a profession became defined as an occupation which is accorded high social status, possesses a specialised body of knowledge obtained through lengthy education and training, is intellectual and practice-based, enjoys relative autonomy in controlling both the education and the performance of its work, and is motivated by altruism and service to society.⁹³

The power and prestige of the professions was largely unquestioned; accepted as the just recognition for the professions’ “special competence in esoteric bodies of knowledge linked to central needs and values of the social system, and because professions are devoted to the service of the public above and beyond material incentives.”⁹⁴

Furthermore, it was believed that there was a continuum of professionalism along which the status of profession or “semi-profession” might be evaluated. In particular, because there were “differences in the prestige attached to law and teaching or

⁹⁰ Larson, 1977, 5.

⁹¹ Larson, 1977, xvi.

⁹² Abbott, A. (1988). *The systems of professions: An essay on the division of expert labour*. Chicago: The University of Chicago Press, 1-5.
Moloney, M. (1992). *Professionalization of nursing*. New York: J.B. Lippincott Company, 3-9.
Salvage, J. (2002). *Rethinking professionalism: The first step for patient-focused care?* [http://www.ippr.org.uk/research/files/team 24/project 13](http://www.ippr.org.uk/research/files/team%2024/project%2013). Accessed 15 March 2004.
Witz, A. (1992). *Professions and patriarchy*. London: Routledge, 40-41.

⁹³ Aaronson, L. (1989). A challenge for nursing: Re-viewing a historic competition. *Nursing Outlook* 37(6), 274-279.
Ballou, K. (1998). A concept analysis of autonomy. *Journal of Professional Nursing* 14(2), 102-110.
Larson, M. (1977). *The rise of professionalism*. Berkeley: University of California Press, x-xi.
Macdonald, K. (1995). *The sociology of the professions*. London: Sage Publications, 2-3.
Moloney, 1992, 8.

⁹⁴ Larson, 1977, x.

medicine and social work”,⁹⁵ study of professions became focused on the notion of a professionalisation process through which particular so-called professional traits and behaviours were achieved. While the specific attributes might vary slightly in their composition, they fell into three general dimensions. The cognitive dimension related to the body of knowledge, the training required, and the way in which the knowledge is applied, particularly the need for case-by-case revision. The normative dimension referred to the ethical and service orientation of the profession, with the evaluative dimension serving as a point of comparison of one profession against another, emphasising characteristics of autonomy and prestige.⁹⁶ Furthermore, it was seen that these special occupations developed into distinct communities in which members shared an identity, personal commitment and loyalty. The community was developed and supported by the establishment of training/professional schools, professional associations and a professional code of ethics.

Medicine came to be seen as the archetypal profession. Freidson⁹⁷ describes in detail the elements of an “ideal-type” profession. It is exemplified by:

1. Specialized work in the officially recognized economy that is believed to be grounded in a body of theoretically based, discretionary knowledge and skill and that is accordingly given special status in the labor force;
2. Exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation;
3. A sheltered position in both external and internal labor markets that is based on qualifying credentials created by the occupation;
4. A formal training program lying outside the labor market that produces the qualifying credentials, which is controlled by the occupation and associated with higher education; and

⁹⁵ Johnson, T. J. (1972). *Professions and power*. London: Macmillan, 21.

⁹⁶ Abbott, 1988, 7-8.
Larson, 1977, x.

⁹⁷ Freidson, E. (2001). *Professionalism: The third logic*. Chicago: The University of Chicago Press.

5. An ideology that asserts greater commitment to doing good work than to economic gain and to the quality rather than the economic efficiency of work.⁹⁸

The “traits and stages” approach continues to persist in the discourse of the professions; and occupations aspiring to attain the prestige and social status accorded professions are expected to develop through a series of common stages of professionalisation.

It could be argued that nurses have “enjoyed the title of professional as much from courtesy as tradition”.⁹⁹ They have also suffered internal conflict over professionalisation ideology and strategies,¹⁰⁰ debated the meaning of professionalism,¹⁰¹ and have been angst-ridden over what was perceived as a lack of professional status.¹⁰² Generations of nurses since at least the mid-twentieth century have debated whether and how nursing might meet a list of characteristics or criteria for a profession.¹⁰³ Nursing, from the mid-1900s, and perhaps to the present day,

⁹⁸ Freidson, 2001, 127.

⁹⁹ Gamer, M. (1979). The ideology of professionalism. *Nursing Outlook* 27(2), 108.

¹⁰⁰ Aaronson, L. (1989). A challenge for nursing: Re-viewing a historic competition. *Nursing Outlook*, 37(6), 274-279.
Baer, E. (1985). Nursing's divided house: An historical view. *Nursing Research* 34(1), 32-38.
Forsyth, S. (1995). Historical continuities and constraints in the professionalization of nursing. *Nursing Inquiry*, 2, 164-171.
Gamer, 1979.
Wilson, K. (1998a). Professional closure: Constructing the image of New Zealand nursing 1880-1940. *Nursing Praxis in New Zealand*, 13(1), 12-22.

¹⁰¹ Carryer, J. (1995). Invisible regulation. *Nursing Praxis in New Zealand*, 10(2), 4-12.
Papps, E. (1997). Knowledge, power, and nursing education in New Zealand: A critical analysis of the construction of the nursing identity. Ph.D. thesis, University of Otago.
Styles, M. (1982). *On nursing: Toward a new endowment*. St. Louis: The C.V. Mosby Company.
Woods, C.Q. (1987). From individual dedication to social activism: Historical development of nursing professionalism, (pp. 153-175). In C. Maggs, (ed.) *Nursing history: The state of the art*. London: Croom Helm.

¹⁰² Chinn, P.L.(ed.). (1994). *Developing the discipline*. Gaithersburg: Aspen Publishers.
Tranbarger, P. (2000). Professionalism in nursing: The struggle to attain professional status. <http://www.home.cwru.edu/~pst/homemain.html> Accessed 22 March 2003.
Salvage, J. (2002). *Rethinking professionalism: The first step for patient-focused care?* <http://www.ippr.org.uk/research/files/team24/project13>. Accessed 15 March 2004.

¹⁰³ Moloney, M. (1992). *Professionalization of nursing*. New York: J.B. Lippincott Company.

both emulates medicine's approaches, and then chastises itself.¹⁰⁴ In this vein, as recently as 1992, Moloney remarked:

True professionals are seldom subject to supervision as are semi-professionals. Other characteristics of semi-professions are a shorter period of training, a less legitimate status, a less specialized body of knowledge, a less established right to privileged communication, and less autonomy from controls than the established professions..... Nurses can advance toward full professionalism if they thoroughly understand the definition and meaning of profession and their responsibilities for achieving full professional status.¹⁰⁵

However, by the 1970s, sociologists, largely drawn from the University of Chicago School of American sociology¹⁰⁶ and others such as Johnson¹⁰⁷ in the United Kingdom had discerned that many of the self-defined professional traits had an ideological or mythological essence – “not only an image which consciously inspires collective or individual efforts, but a mystification which unconsciously obscures real social structures and relations.”¹⁰⁸ As sociologists revisited their study of the professions, more pluralistic understandings began to supplant the trait and stages approach.

While the earlier sociological approaches put great store in the moral authority and altruism of the professions, the more critical approach, examining the interplay between the state and society, shifted the emphasis from traits and structure to an action-oriented consideration. “The sociological question changed from ‘What part do the professions play in the established order of society?’ to ‘How do such

¹⁰⁴ Tranbarger, P. (2000). *Professionalism in nursing: The struggles to attain professional status*. <http://www.home.cwru.edu/~pst/homemain.html>. Accessed 22 January 2003.
Moloney, 1992, 8-10.

¹⁰⁵ Moloney, 1992, 9-10.

¹⁰⁶ Larson, 1977, xii.
Macdonald, 1995, xiii, 27.

¹⁰⁷ Johnson, 1972.

¹⁰⁸ Larson, 1977, xviii.

occupations manage to persuade society to grant them a privileged position?”¹⁰⁹ In considering the answer to this question, issues of social class, gender, division of labour, patriarchy and the state were explored. It began to be seen that the professions were not wholly altruistic agents of society, but rather, they “imposed both definitions of needs and manner of service on atomised consumers”.¹¹⁰

In one sense “profession” is a term bestowed by the laity, and

assessing whether an occupation is or is not a profession, is a “semi-profession”, or is more or less professional than other occupations, is what the ‘folk’ do....Customers, patients and clients are continuously aware of the performance in all manner of aspects of members of occupations: they monitor, assess and evaluate and thereby produce the climate of opinion which provides the background for ‘professional’ standing and at certain junctures may become quite crucial.¹¹¹

The state and employers also assess the claims of occupational groups. The views of either the state or employers, and the sanctions arising from their respective appraisals may or may not be consistent with those of the laity. Thus, while the practice opportunities accorded to a profession depend on the broad societal context that shapes the need for a given service, the state has a central role in terms of its sponsorship of monopolistic educational systems for professions and sanction for scopes or markets of practice. Larson concluded that while professions originally emerge by the grace of the elite and powerful, they “ultimately depend upon the power of the state.”¹¹²

¹⁰⁹ Macdonald, 1995, xii.

¹¹⁰ Abbott, 1988, 5.

¹¹¹ Macdonald, 1995, 7.

¹¹² Larson, M. (1977). *The rise of professionalism*. Berkeley: University of California Press, xii.

Magali Larson's work, *The Rise of Professionalism* is particularly important to the contemporary understandings of professions.¹¹³ Larson's work emphasises that the attributes of special expertise, higher education, a discreet body of knowledge or ethical standards do not assure the rewards of professional status. While these features may be necessary, professionalisation is not solely a process of development of idealised group characteristics; rather it is the ways in which the producers of special services seek "to constitute and control a market for their expertise".¹¹⁴ She argued that,

Professionalization is thus an attempt to translate one order of scarce resources - special knowledge and skills - into another -social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification. The focus on the constitution of professional markets leads to comparing different professions in terms of the "marketability" of their specific cognitive resources. ...The focus on collective social mobility accentuates the relations that professions form with different systems of social stratification; in particular it accentuates the role that educational systems play in different structures of social inequality.¹¹⁵

Professionalisation, then, is the result of what Larson termed "the professional project".¹¹⁶ In this usage, the term "project" may be misleading, as it suggests a well defined, planned undertaking. However in this sociological usage, professional project,

does not mean that the goals and strategies pursued by a given group are entirely clear or deliberate for all the members, nor even for the most determined and articulate among them. Applied to the historical results of a

¹¹³ Larson, 1977.

¹¹⁴ Larson, 1977, xvi.

¹¹⁵ Larson, 1977, xvii.

¹¹⁶ Larson, 1977, xii.

given course of action, the term 'project' emphasizes the coherence and consistence that can be discovered *ex post facto* in a variety of apparently unconnected acts.¹¹⁷

Andrew Abbott's work on professions added to Larson's concept of the professional project. Abbott argued that to understand a profession's development, rather than focusing on its organisational, structural or cultural development, one must examine the profession in terms of changes in its work, particularly in relation to groups which share related work. He emphasised the importance of dynamic interdependence, inter-professional competition, and jurisdictional dispute across related professions. He asserted that interprofessional competition is "a fundamental fact of professional life", and that "jurisdictional boundaries are perpetually in dispute both in local practice and in national claims."¹¹⁸

For Abbott, the key feature of a profession's development is its jurisdiction, and how it is "anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves".¹¹⁹ As to the rise and fall of professions, Abbott offers reminders of the various occupational groups which have "stalled or even died on the high road of professionalization – psychological mediums, electrotherapists and railway surgeons, computer 'coders'..."¹²⁰ and other professions which have merged, such as the homeopaths and "regular medicine".¹²¹ He argues that new professions,

develop when jurisdictions become vacant, which may happen because they are newly created or because an earlier tenant has left them altogether or lost its firm grip on them. If an already existing profession takes over a vacant

¹¹⁷ Larson, 1977, 6.

¹¹⁸ Abbott, A. (1988). *The systems of professions: An essay on the division of expert labour*. Chicago: The University of Chicago Press, 2.

¹¹⁹ Abbott, 1988, 3.

¹²⁰ Abbott, 1988, 18.

¹²¹ Abbott, 1988, 20.

jurisdiction, it may in turn vacate another of its jurisdictions or retain merely supervisory control of it.¹²²

Therefore Abbott's sociology of professions argues for historical studies of jurisdictional control, rather than the traits and stages view of professionalisation. Abbott's emphasis on jurisdictional dispute is not incompatible with Larson's concept of the professional project, and I believe it adds a useful perspective to nursing's professional project, and particularly to the examination of the development of contemporary "advanced nursing practice".

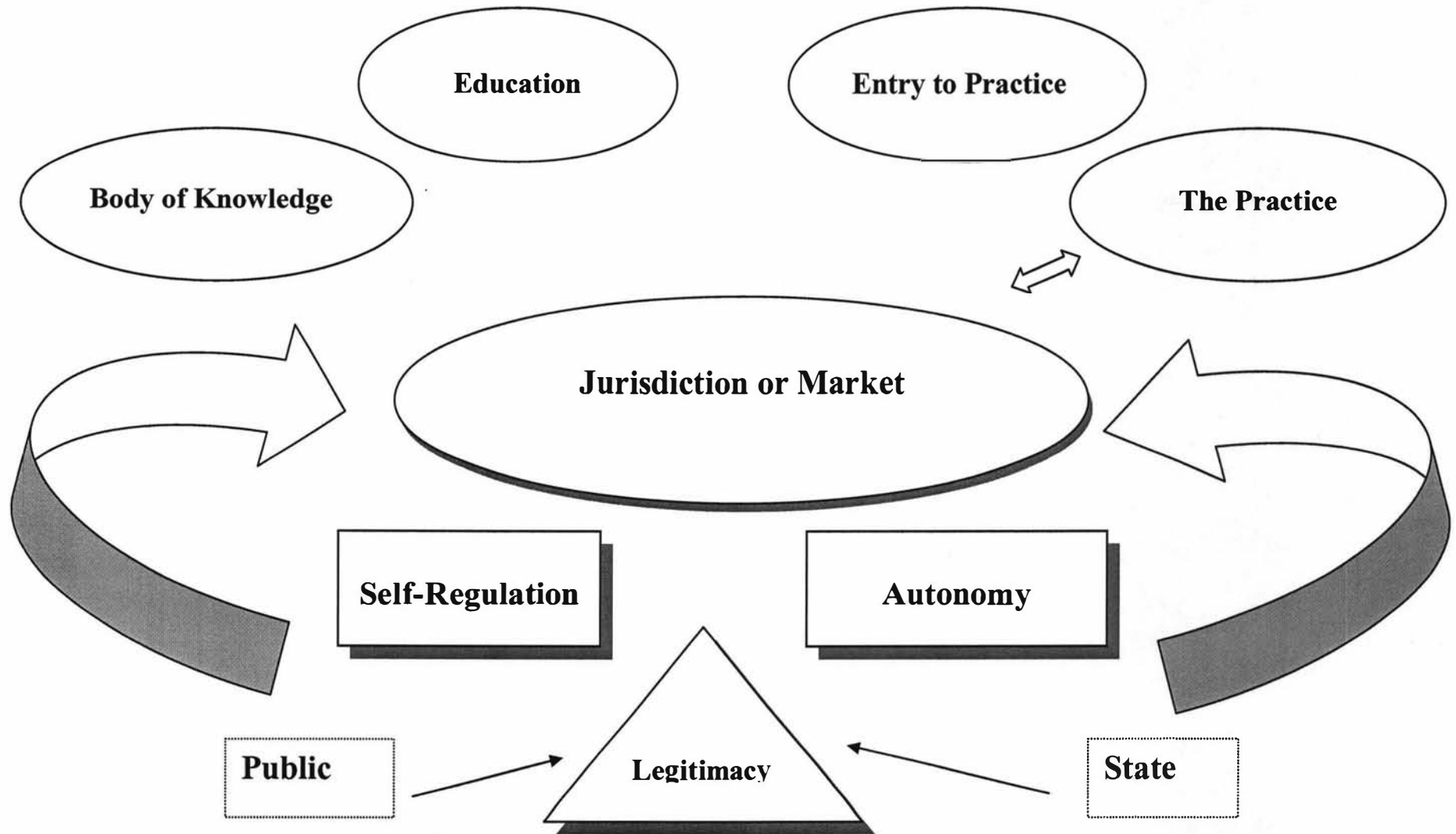
Drawing these elements together, a professional project is thus, a process through which an occupational group gains control over an abstract body of knowledge, the education and entry to practice of practitioners; secures legitimacy through the state and the public; achieves autonomy and self-regulation over its practice; and secures, maintains and extends a market, or a jurisdiction for itself.¹²³

An illustrative overview of key elements of the professional project and professionalisation is shown in Figure 12. This illustrates the profession's body of knowledge, its formal training and education, its control of entry to practice underpinned by degrees of self-regulation and autonomy. It depicts the pivotal roles of the state and society in granting special privilege to the profession, and access to markets or jurisdictions in which to practice or carry out particular activities.

¹²² Abbott, 1988, 3.

¹²³ Abbott, 1988.
Popp, E. (2001). *Creating a national medical field: the associated apothecaries and surgeon-apothecaries, the provincial medical and surgical association and the first professional project*. Retrieved 6 January 2004 from <http://ist-socrates.berkeley.edu/~irr/culture/paper>

Figure 12
The Professional Project



Anne Witz concluded, “professional projects are by their very nature divisive”.¹²⁴ Differences in class, gender, personal experiences, values and beliefs have caused gulfs within nursing throughout its history. My thesis will illustrate these differences and the occasions of division in New Zealand nursing’s professional project. It will demonstrate that advanced nursing practice and the development of the Nurse Practitioner have been – *ex post facto* - part of New Zealand nursing’s professional project. This historical sociological study will explicate the network of actions and reactions that have led to this point in the project.

Professional agendas, politics and political sophistication

The model of profession has altered over the twentieth century, but,

in this age of corporate capitalism, the model of profession nevertheless retains its vigor; it is still something to be defended or something to be attained by occupations in a different historical context, in radically different work settings, and in radically altered forms of practice.¹²⁵

While the usage of the term profession may refer to a form of organisation, indicate a level of social status or knowledge, or a way of organising a career, “our ambivalent concept holds them all together ... and acquires its power precisely from the yoking of these often disparate realities”.¹²⁶

The drive to achieve a model of profession and a preferred position in the context of time – nursing’s professional project – is shaped by a range of forces. Key forces in the history of nursing’s development include its leadership, national and international nursing networks and organisations, knowledge development in the discipline, problems in the health sector, and the responses to these problems. These are consistent with Margretta Styles’ conceptualisation of factors that support a

¹²⁴ Witz, A. (1992). *Professions and patriarchy*. London: Routledge, 130.

¹²⁵ Larson, 1977, xviii.

¹²⁶ Abbott, 1988, 318.

professional field or occupation.¹²⁷ Styles defines such factors as “conditions that in combination lead to a result”.¹²⁸

Drawing on the earlier work of Roy and Martinez¹²⁹ relating to the clinical nurse specialist, Styles outlines factors internal and external to the profession.¹³⁰ External factors include conditions in the health-related environment. Health needs within the overall population and within special population groups; governmental health policy; conditions within the overall health workforce; and conditions favouring innovation and change within the health system, all influence health disciplines. These external factors are often opportunity factors.

Within a health profession, a number of other conditions contribute to its development, or its ability to advance an agenda. According to Styles, these include the

1. “Potential” of the profession;
2. Strength within the profession to advocate, promote and advance a new development;
3. Existence of an organisation “to mobilize the practitioners and enable them to exert control over the standards and influence of the field, promote the development of a literature and sound educational programmes, and represent the field within the external environment”;
4. Manifestations of the profession’s strength, such as lobbying for new policies, laws, other support;
5. Willingness to accord a certain status to a group within its membership; and the
6. Development of a significant research base.

¹²⁷ Styles, M. (1996). Conceptualizations of advanced nursing practice. In A.B. Hamric, J.A. Spross, & C.M. Hanson (Ed.), *Advanced nursing practice: An integrative approach*. (pp.25-41). Philadelphia: W.B. Saunders, 28-30.

¹²⁸ Styles, 1996, 28.

¹²⁹ Roy, Sr.C. & Martinez, C. (1983). A conceptual framework for CNS practice. In A.B. Hamric & J. Spross. *The clinical nurse specialist in theory and practice*. (pp. 3-20) Orlando: Grune & Stratton.

¹³⁰ Styles, 1996, 28-30.

Consideration of these factors is useful in examining nursing's ability to "advance" a particular agenda, to sustain its place in the eyes of the community, the state, or the health care environment, and its overarching professional project. However there is a deeper layer. The process of political agenda setting, the emergence of particular governmental department policies, and the degree or state of nursing's political astuteness are critical underpinnings of this framework.

John Kingdon explored the complex processes by which political agendas are established.¹³¹ While his research relates to the United States government, similarities are reflected in the development of New Zealand policy agendas. Kingdon noted that a surge in the perception of pressing problems - either a steadily mounting concern or a sudden crisis can urgently move a problem up the agenda. In New Zealand in the 1980s and 1990s, failure to achieve a decrease in morbidity from diabetes, coronary artery disease, hypertension and renal disease, coupled with concerns about access to primary health care, finally led to the successful government push for the establishment of primary health care organisations and Ministry of Health scholarships for postgraduate study in primary health care nursing in the first years of the 2000s.

Another impetus for a particular political agenda may be a gradual process of the development of understanding and perspectives among the specialists in government departments, individual experts, private consultants, interest groups, and the generation of policy proposals by such specialists.¹³² But independent of such knowledge, agendas may be built through the process of frequent discussion, lobbying, speeches, hearings, and the like. Thirdly, political processes, such as changes in government, new political appointments, alterations in national mood, or a politician's desire to build a constituency may also affect political agendas. The

¹³¹ Kingdon, J. W. (1995). *Agendas, alternatives and public policies*. New York: Addison Wesley Longman, Inc.

¹³² Kingdon, 1995, 17.
Shaw, R. (2001). Advisers and consultants. In R. Miller, (Ed.) *New Zealand government and politics* (pp. 145-157). Auckland: Oxford University Press.

position, power and effectiveness of nursing's leadership, networks and organisations are both constituted and underpinned by these political processes.

While an issue may surface and policy advice be generated, a course of action may or may not be taken. However, when a compelling problem is matched with a policy proposal in a situation of favourable politics, a window of opportunity is opened. "Policy entrepreneurs"¹³³ is the term Kingdon uses to describe people who help to open the windows of opportunity. These are people who "invest their resources in pushing their pet proposals or problems, are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems, and for coupling both problems and solutions to politics".¹³⁴ Most, if not all of the knowledgeable informants for this study may be characterised as policy entrepreneurs.

Margaret Wilson cited David Held's explanation of politics as

the discourse and the struggle over the organisation of human possibilities. As such, it is about power; that is to say, it is about the capacity of social agents, agencies and institutions to maintain or transform their environment, social or physical. It is about the resources that underpin this capacity and about the forces that shape and influence its exercise....Accordingly, politics is a phenomenon found in and between all groups, institutions and societies, cutting across public and private life...¹³⁵

For most of nursing's modern history, while individual women may have achieved political influence, women as a whole had relatively little public power. In New Zealand, women gained suffrage in 1893, but the barriers imposed by gender roles, and consequent social and economic positions, continued to impede women's political power over a long period.¹³⁶ Margaret Wilson noted that "it is arguable that women

¹³³ Kingdon, 1995, 20.

¹³⁴ Kingdon, 1995, 20.

¹³⁵ Wilson, M. (2001). Women and politics. In R. Miller, ed. *New Zealand government and politics*. (pp.375-385), Auckland: Oxford University Press.

¹³⁶ Wilson, 2001, 378.
Kalisch, B.J. & Kalisch, P.A. (1982). *Politics of nursing*. Philadelphia: J. B. Lippincott.

have begun to have political influence since the mid 1980s”.¹³⁷ Thus it is not surprising to hear an argument advanced that “the body” of nursing is only just beginning to develop more astute and complex approaches to politics—and that nursing still struggles to be heard when decisions are being made about nursing or health policy.¹³⁸

Working in the United States, Sally Cohen, Diana Mason and colleagues describe stages of nursing’s evolution as a body politic. While Cohen et al. acknowledge that individual nurses may develop politically at different rates or manner distinct from the profession as a whole, they postulate four stages which may characterise the political development of the profession.

In the beginning stage of “buy-in”, the profession recognises the importance of political activism, and political awareness and involvement of individual nurses is encouraged. At the same time, the difficulties for nursing in obtaining power are beginning to be understood, and strategies for becoming involved are explored. An awareness of the importance of health policy in nursing curricula may also occur.

Stage two involves activities that serve to enhance nursing’s identity. Cohen et al. refer to this as a “self-interest” stage, but it is self-interest in the sense that the profession pulls together. The development of special-interest groups, as well as coalitions within nursing often occur at this time. There is a “growing acknowledgement of the importance of nurses working together, or at least showing a united front, despite differences of opinion among individuals and groups”.¹³⁹ However, in this stage, nursing tends to use its own jargon, necessitating “translation” to non-nurses such as the public and Parliamentarians. While this may be a barrier, it

¹³⁷ Wilson, 2001, 378.

¹³⁸ Hughes, F. (2001). Locating health policy and nursing: Time for a closer relationship. *Nursing Praxis in New Zealand*, 17(3), 6.
Cohen, S., Mason, D., Kovner, C., Leavitt, J., Pulcini, J. & Sochalski, J. (1996). Stages of nursing’s political development: Where we’ve been and where we ought to go. *Nursing Outlook*, 44(6), 259-266.
Carryer, J. (1995). Invisible regulation. *Nursing Praxis in New Zealand*, 10(2), 4-12.

¹³⁹ Cohen, S. et al., 1996, 261.

is not necessarily a block, as Cohen et al. correlate the successful lobbying for changes in the legal framework that enabled advanced practice nursing in the United States as indicative of this stage.

By stage three, nurses have become more fluent in the language of policy and politics, and are able to employ more sophisticated strategies in political activism.

Increasingly, governmental policy leaders and others recognise the expertise and talents that individual nurses and the profession can bring to health policy processes, and thus this stage is marked by the appointment of nurses to important organisational, agency and governmental policy-related groups.

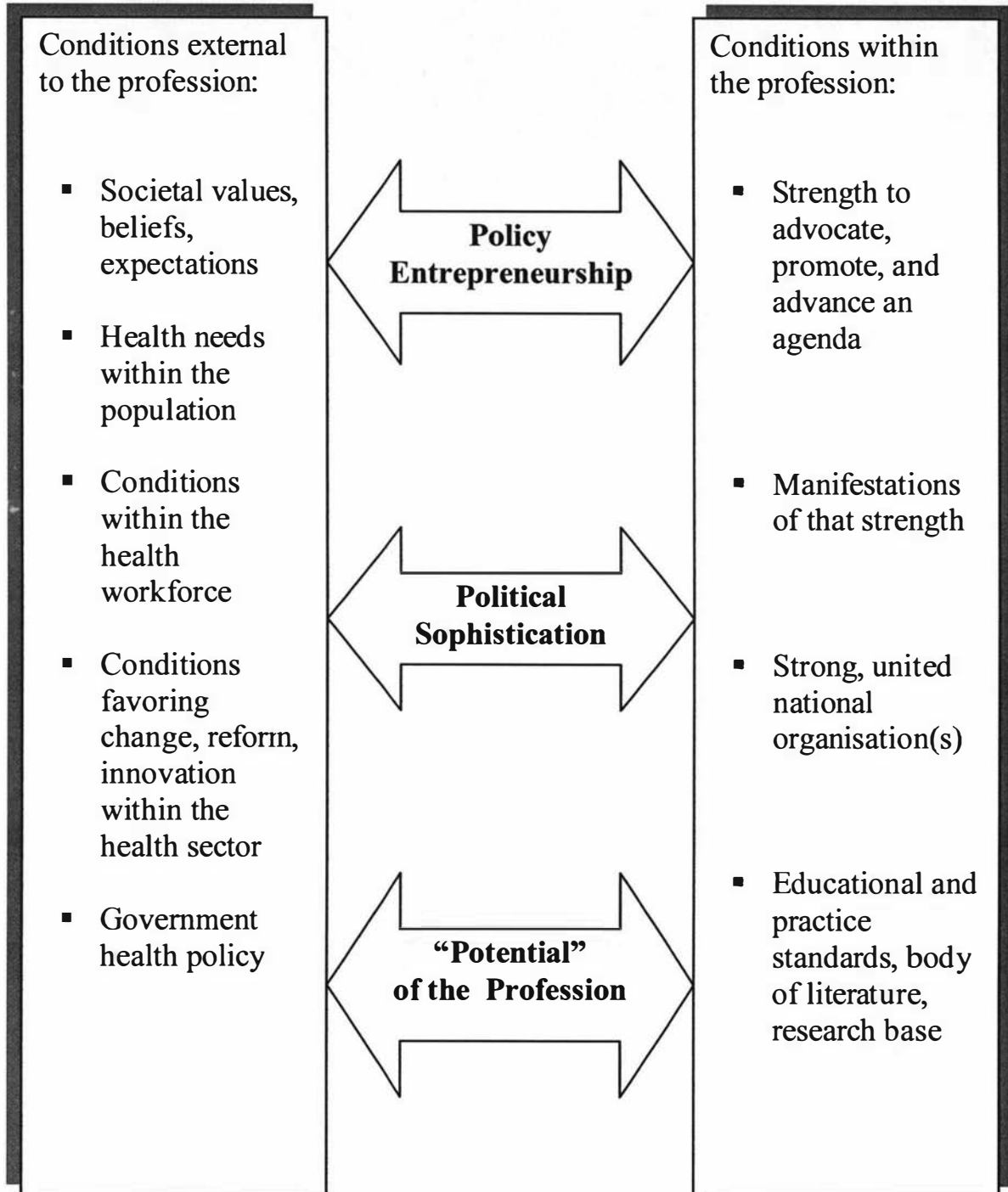
“Leading the way” or “agenda-setting” describes a fourth stage of political development. This stage is characterised by a recognition of nursing’s leadership in the wide range of health and social policy areas, beyond what might have been considered nursing’s traditional purview.

Towards a theory of development: Factors supporting the professional project

In describing factors that support a professional field or occupation, Styles was specifically referring to the development of advanced nursing practice in the United States. However, this framework can be seen to apply to any development within the profession. Drawing on the work of Styles, Kingdon and Cohen et al., I have conceptualized an expanded descriptive framework of factors which support the development of nursing. This is illustrated in Figure 13.

Figure 13

Factors Supporting the Professional Project: A Framework for Nursing



This thesis argues that the forces and voices influencing the development of concepts of advanced nursing practice over time, including the development of the Nurse Practitioner at the turn of the 21st century, can be understood within the concept of a professional project, particularly a framework of factors – as per Styles’ “conditions which lead to a result”.¹⁴⁰ It will argue that all of these factors were present in the mid-to late 1990s, to such an extent as to permit the expansion of nursing practice into legitimated diagnosis and treatment of health concerns – jurisdictions previously considered to be the near-exclusive province of medical practitioners.

Conclusion

This chapter has examined theoretical perspectives arising from sociology, political science and nursing that have informed a framework for exploring the development of advanced nursing practice in New Zealand in the late 1990s – the professional project and factors supporting nursing’s professional project. The following chapter explores the range of historical and contemporary connotations and meanings of the concept of “advanced nursing practice”. This enables these meanings to be traced over time in subsequent chapters which explore New Zealand nursing development, leading to a “case study” of the New Zealand advanced nursing practice project.

¹⁴⁰ Styles, 1996, 28.

Chapter 3: The Evolution of Meanings of Advanced Nursing Practice

Time present and time past
Are both perhaps present in time future,
And time future contained in time past.
“Burnt Norton”¹⁴¹

Introduction

Advanced is defined as “raised in rank; promoted; moved ahead or beyond in progress, complexity, etc”¹⁴² and “far on in any course of action, or march of ideas”.¹⁴³ “Practice” ostensibly refers to any or all aspects of the work of the registered nurse -“the actual performance or application; the exercise of a profession or occupation; the doing of something as an application of knowledge”,¹⁴⁴ or “the practical aspect or application of something as opposed to the theoretical aspect”.¹⁴⁵

Connotations of the word “advanced” as applied to *nurse*, the *practice of nursing* and the *profession of nursing* have evolved over time. The particular meanings ascribed to “advanced nursing practice” in New Zealand at the turn of the 21st century were debated in the late 1990s, and promoted at a conference sponsored by the Ministry of Health and the Nursing Council of New Zealand in August 2001 to “launch” the New Zealand Nurse Practitioner. As defined by the Nursing Council of New Zealand in 2001, advanced nursing practice

has a clinical or therapeutic focus. It is the integration of research-based theory and expert nursing in a clinical practice area, and combines the roles of practitioner, teacher, consultant, and researcher to advance the professional

¹⁴¹ Eliot, T. S. (1969). *The complete poems and plays of T.S. Eliot*. London: Faber & Faber.

¹⁴² Guralnik, D. B. (ed.). (1970). *Webster's new world dictionary*. New York: The World Publishing Company.

¹⁴³ Brown, L. (ed). (1993). *The new Shorter Oxford English dictionary*. Oxford: Clarendon Press.

¹⁴⁴ Guralnik, 1970.

¹⁴⁵ Brown, 1993.

practice of nursing (Canadian Nurses' Association, 1997). Advanced nursing practice reflects a range of highly developed clinical skills and judgments acquired through a combination of nursing experience and education. Essentially, advanced nursing practice requires the application of advanced nursing knowledge, with practitioners drawing not only from their clinical experience, but also on the experience and research of the profession as a whole.¹⁴⁶

Drawing on the Canadian Nurses' Association's definition of advanced nursing practice, this New Zealand statement reflects movements which originated in the United States, and have spread throughout North America, Australia and the United Kingdom.

Five key emphases feature here: 1) a focus on an expert clinical practitioner; 2) an emphasis on research; 3) the expectation that this expert clinical practitioner is also a capable teacher, consultant and researcher; 4) the stipulation that higher level professional education is required; and 5) the belief that this practitioner is critical to the advance of the professional practice of nursing.

However, are these elements in fact "new" to what has been understood about "advanced" nursing? This chapter explores various connotations and meanings of the concept of advanced nursing practice in New Zealand in historical and contemporary contexts. It demonstrates how particular meanings of advanced nursing have developed and evolved over time. There have been many. For example, the advanced nurse has been seen as the nurse with higher education; with more than one type of nursing registration; as the nurse practising with less direct supervision or more autonomously; as the specialist nurse; as one with a particular title within a hierarchy of nursing titles; and most recently, as a masters-prepared nurse with an apparent combination of all of the fore-going features.

¹⁴⁶ Nursing Council of New Zealand. (2001 a), *Framework for post-registration nursing education*. Wellington: Author, 28.

Advanced: Further or higher education

Higher-level education is not a new element in the notion of advanced practice. Calls for nursing education to be within the university system began within the decade following statutory nursing registration. In part this was stimulated by overseas developments. For instance, the New Zealand nursing journal *Kai Tiaki* which began in 1910, was able to report news of a nursing degree at the University of Minnesota soon after the latter began in 1909.¹⁴⁷

Speaking at the opening of a new nurses' home in 1912, Dr. Pabst, of Auckland Hospital, urged the University of New Zealand to institute a degree in nursing.¹⁴⁸ However, in an editorial in *Kai Tiaki*, Hester Maclean, Assistant Inspector of Hospitals, Asylums and Charitable Institutions, founder of the New Zealand Trained Nurses' Association (NZTNA), and of *Kai Tiaki*, reflected Florence Nightingale's ambivalence towards education.

While we do not wish to discourage the higher teaching of nursing nor the desire to bestow honour on a profession...we must not forget that of equal importance in the training of nurses is the education of the hands as well as the brain.¹⁴⁹

Nightingale's view was that nurse training should be hospital ward-based, and while she opposed what came to be universal use of nurses-in-training for ward cleaning, she also opposed the idea that they should be given formal education such as a "preliminary training school" in such subjects as anatomy and physiology before they commenced their ward-based training.¹⁵⁰ Thus, "education of the hands" came ahead

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- ¹⁴⁷ Bullough, V. & Bullough, B. (1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm, 159.
Hughes, B. (1978). Nursing education: The collapse of the Diploma of Nursing at the University of Otago, 1925-1926. *New Zealand Journal of History* 12(1), 17-33.
- ¹⁴⁸ Kinross, N. (1984 a). Nursing education in New Zealand: A developmental perspective. *International Journal of Nursing Studies* 21(3), 194.
- ¹⁴⁹ Maclean, 1912, cited in Miller, N. (1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses' Association, 79-80.
- ¹⁵⁰ Baly, M. (1986). *Florence Nightingale and the nursing legacy*. London: Croom Helm, 209-210.

of the brain. This ethos preserved the necessity of learning by repetition and discipline, forbearance and obedience, rather than through intellect and understanding of abstract knowledge. “The Nightingale ethos was incompatible with advanced training for nurses.”¹⁵¹

Following World War I and the influenza epidemic of 1918, many countries became more aware of the skills and contributions of nurses, and the value of education to a developing profession. By 1922, there were seventeen degree programmes for nursing in the United States, and in the United Kingdom, a diploma programme in nursing commenced at the University of Leeds.¹⁵² At this time the NZTNA initiated a campaign to establish a programme of higher education for nurses in New Zealand. This gained the support of the Superintendent of the Dunedin Hospital, Dr. Falconer, and the University of Otago. Representatives from the NZTNA and the University of Otago decided

that the best and simplest way to promote advanced education for nurses would be to institute a Diploma in Nursing which the University could approve, rather than a degree which would require the approval of the Senate of the University of New Zealand.¹⁵³

By 1923 a five-year Diploma in Nursing had been approved in principle by the University Council. The first two years of the programme would consist of studies in chemistry, anatomy, physiology, cookery, homecraft, dietetics, sanitary science, bacteriology and basic nursing. Years three and four would provide hospital training, and during the fifth year, the student could study either nursing education, administration, or public health nursing.

¹⁵¹ Rodgers, J. (1985). Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. M.A. thesis, Massey University, v.

¹⁵² Bullough, V. & Bullough, B. (1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm, 159.

¹⁵³ Hughes, 1978, 22.

The New Zealand Department of Health, giving tacit support for the proposal, sponsored Janet Moore and Mary Lambie to study abroad for their roles as nursing lecturers. But by 1925 it was clear that the University and the Department of Health had different views on who should provide the salaries of the nursing lecturers, and the programme which had commenced with three students, was at serious risk.

The NZTNA made every effort to save the programme – even raising funds from its own members. But the programme lapsed. Hughes noted that not only would it have cost £10,000 for the University of Otago to establish the diploma programme, it did not have a commitment to nursing education to drive such expenditure. In New Zealand in the 1920s, “the Department provided basic training, but advanced education for nurses was a relatively new idea and one which many people thought unnecessary.”¹⁵⁴ At a time when only 50% of young people went on to secondary school,¹⁵⁵ in general, higher education for women was considered superfluous.

There were other related forces at work in the demise of the programme. The University Council, particularly the professorial and medical representatives, reflected a conservative view of education for women. Perhaps even more importantly, “there appeared to be no one of great influence in Otago who was ...quick to perceive the advantages of postgraduate study not only to the nursing profession but ultimately to the community”.¹⁵⁶ Neither a local nor a national “policy entrepreneur”¹⁵⁷ was present to champion this cause.

Janet Moore and Mary Lambie returned to New Zealand in 1926, eager to use their education and experience as lecturers in the planned University of Otago programme, only to find there were no positions to take up. In 1927, with syllabuses of nursing programmes from the University of Toronto and Bedford College, they approached

¹⁵⁴ Hughes, 1978, 33.

¹⁵⁵ Belich, J. (2001). *Paradise reforged: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press, 154.

¹⁵⁶ Hughes, 1978, 31.

¹⁵⁷ Kingdom, 1995, 20.

Professor Hunter at Victoria University.¹⁵⁸ They also discussed their ideas with Jessie Bicknell, Director of the Division of Nursing, and Dr. Valintine, Director-General, Department of Health. Within a year, a six-month, post-registration programme was established. Management of the programme was organised as a tripartite arrangement among Victoria University, the Wellington Hospital, and the Department of Health.¹⁵⁹ However the ultimate control rested with the latter. This was the beginning of the Postgraduate School for Nurses, later renamed the School for Advanced Nursing Studies (SANS).

The first formal use of the word “advanced” applied to nursing appears to be in the renaming of the Postgraduate School for Nurses as the School for Advanced Nursing Studies. In his introduction to the 1971 Annual Report of the Department of Health, Dr. D.P. Kennedy recorded

In April 1970 the title of the post-basic school for the preparation of nurse leaders was changed from the New Zealand Postgraduate School for Nurses to the New Zealand School of Advanced Nursing Studies....Some students, particularly those from overseas, believed they were enrolling in a postgraduate programme while what the school offered was post-basic programmes.¹⁶⁰

The notes of the meeting at which the Management Committee of the Postgraduate School for Nurses considered the change in title do not elucidate the origin of the dissatisfaction with the title of the School, but merely note that “the Director-General of Health was considering a paper on a proposed change of title for the Postgraduate School”.¹⁶¹ Shirley Bohm, Director of the Division of Nursing at that time, and member of the Management Committee explained that in the preceding years, when she had accompanied Alma Reid on her consultancy visits regarding the establishment

¹⁵⁸ Hughes, 1978, 30.

¹⁵⁹ NA, H H1, I-22, 33318, 1/11/25Historical papers related to the Postgraduate School for Nurses.

¹⁶⁰ AJHR H-31 1971, 80.

¹⁶¹ N.A. H, W2191, 1/23/2 ptl (40390) bx 48 Nursing NZSANS Advisory Committee

of nursing education in universities, “we always had difficulty with this word postgraduate”.¹⁶² Alice Fieldhouse, an instructor at the Postgraduate School in 1969-72, commented that she understood the change of name was effected “by some of the external lecturers (to the Postgraduate School) from the Teachers’ College and universities who were not used to the word being used outside the universities”.¹⁶³

It is interesting to note that this name change occurred at a time of strengthening commitment to move nursing training into the education system. It is not clear whether, after forty-one years of existence as the Postgraduate School for Nurses, the change in title was part of a careful strategy, or whether it was precipitated by a growing awareness of the anomalous situation of nursing education in New Zealand.

From its foundation in 1928 until the first post-registration degree programmes - which specifically included nursing as a subject – were established at Victoria and Massey universities in 1973, SANS was the only educational institute offering higher education in nursing in New Zealand. Over its fifty year history, fewer than 2000 New Zealand nurses were granted the SANS diploma.¹⁶⁴

Education for nursing has been hotly contested since Florence Nightingale took her nurses to Scutari. While nursing training provided “education” beyond secondary schooling, it was not seen as higher, or advanced education. It was clearly regarded as training and service considered appropriate to women. In the 1920s, nurse trainees were required only to have completed schooling through Standard Six (sixth year of primary school).¹⁶⁵ Historically, higher education for women had been long dismissed. Later, when acceptable, it was nevertheless reserved for only a privileged minority.

¹⁶² Interview recorded with S. Bohm, 25 March 2000.

¹⁶³ Interview recorded with A. Fieldhouse, 8 June 2000.

¹⁶⁴ AJHR, 1977, H-31.

¹⁶⁵ Rodgers, J. (1985). Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. Thesis, M.A., Massey University, 56.

Advanced: Outside the hospital walls

Although “modern” nursing’s origin is the hospital-trained nurse, early trained nurses returned to nursing’s roots in the home and community. Views of whether the more “advanced” nurse was one who worked in the hospital or one who worked in the community have fluctuated in tune with societal beliefs and values. These views were in turn influenced by discourses relating to nursing’s association with the more powerful medical profession, particularly in the early years following nursing registration, and later, with society’s awe of technology which grew in the latter part of the twentieth century. At other times, community nursing has been valued, particularly because of its connectedness with families and communities, and perhaps because its agency for those it served was more apparent.

Community nursing in New Zealand in a formal sense was established by Sibylla Maude in Christchurch in 1896, when she contracted with Anglican churches in the area to provide area nursing services.¹⁶⁶ By 1909 St. John Ambulance Association and hospital boards had also appointed district nurses.¹⁶⁷ A Native Health Nursing Scheme, established primarily to prevent the spread of infectious diseases and epidemics from Maori communities to pakeha¹⁶⁸ communities, was established in 1911.¹⁶⁹

This extension of practice beyond the narrow focus of the hospital-oriented training often required further education and training. Not long after the establishment in 1907 of the Royal Society for the Health of Women and Children – which became known as the Plunket Society, as a result of the support of the wife of the then Governor-General, Lady Victoria Plunket - post-registration training for nurses in infant welfare was established.¹⁷⁰ Plunket nurses, as they were known, made home visits as well as held community-based clinics in specially designated “Plunket

¹⁶⁶ Sargison, P. (1993). *Notable women in New Zealand health*. Auckland: Longman Paul, 9.

¹⁶⁷ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 16.

¹⁶⁸ Pakeha is a Maori word which refers to non-Maori, generally of “white” skin.

¹⁶⁹ McKillop, 1998, 52.

¹⁷⁰ Burgess, 14.

Rooms”. This training has endured, continuing to the present, and has received Government support since the early years.

By contrast, there was no special preparation for nurses appointed to the Native Health Nursing Scheme.¹⁷¹ It seems probable that the view of further preparation for these roles was a self-serving tool of those in control of the services. Plunket training enhanced the image of the Plunket Society, and the upper and middle classes which supported it. On the other hand, the lack of further preparation for the Native Health Nursing Scheme was an expedience for the Native Health and Public Health departments and reflected the subordinate status of Maori.

Within the hierarchical systems that prevailed in the first half of the 20th century, district and public health nurses, working at a distance from the hierarchy and direct supervision of the training hospital experienced greater freedoms and autonomy.¹⁷² Indeed, Sibylla Maude’s return to the community, leaving her position as Matron of the Christchurch Hospital, was sparked by what she saw as challenges to her legitimate authority by the hospital board.¹⁷³

In crises such as war, from the Crimean and the American civil war, to the two world wars, the power and place of nurses (and women in general) working in those situations are often said to have advanced. The truth is perhaps more like “advance and retreat”. In each of those wars, paternalistic attitudes and frank misogyny were pervasive. In World War I, and to a very large extent in World War II, New Zealand nurses were denied rank and pay commensurate with their training; struggled to maintain their status as possessors of specialized knowledge and skill as orderlies and aides were often given responsibilities and authority equal to that of nurses; and were thoroughly subordinated within the military system.¹⁷⁴

¹⁷¹ McKillop, 52.

¹⁷² Linebach, in Maggs C. (ed.) (1987). *Nursing history: The state of the art*. London: Croom Helm.

¹⁷³ Sargison, 1993, 9.

¹⁷⁴ Pengelly, E. (1956). *Nursing in peace and war*. Wellington: The Wingfield Press.
Rogers, A. (2003). *While you're away: New Zealand nurses at war 1899-1948*. Auckland: Auckland University Press.

However, the acclaim for nurses' patriotism, bravery and skill in war added to their professional status, and advanced nursing. While the favourable response of politicians to the Nurses Registration Bill in 1901 was founded on the belief in nurses' womanly dedication, the service of New Zealand nurses in the Boer war perhaps made some contribution to the success of the bill.

In spite of military hierarchy, and the projected image of the nurse "carrying out the traditional work of women"¹⁷⁵ within the confines of a military hospital far from the front, nurses were increasingly moved to the front lines to ensure timely treatment and care of the wounded. There, nurses gained new respect for their knowledge and skill, and their adaptability and bravery in front-line situations. New treatments and medical technologies developed as a result of war injuries expanded and advanced nursing knowledge and skill, with those in military service being the vanguard.

During World War I, nurses acted as anaesthetists, and took on many pre- and post-operative patient care responsibilities previously only carried out by surgeons.¹⁷⁶ It seems likely that New Zealand nurses, like their counterparts in other countries, had been administering anaesthesia for some time.¹⁷⁷ In 1918 Mr. J. Vigor Brown of Napier wrote to the Minister of Public Health, Mr. C.W Russell, suggesting that nurses be permitted to administer anaesthesia. He argued that,

Owing to the scarcity of Doctors now, it seems to me that the time has arrived when some of the Sisters should be able to better their positions. We have women chemists now, in fact, women are occupying nearly every position in the World (except being members of Parliament).¹⁷⁸

Rodgers, J. (1994). 'A paradox of power and marginality': New Zealand nurses' professional campaign during war, 1900-1920. Ph.D. thesis, Massey University.

¹⁷⁵ Rodgers, 1994, 256.

¹⁷⁶ Rodgers, 1994, 194.

¹⁷⁷ Bigbee, 1996, 5-6.

¹⁷⁸ N.A., H-21, 22734, 21/10 Nurses acting as anaesthetists.

The Minister of Public Health wrote to the Solicitor-General for an opinion on the matter, who in turn, forwarded the question to Hester Maclean, Assistant-Inspector of Hospitals, and Deputy-Registrar of Nurses. It was her opinion that,

There is nothing to prevent nurses acting as anaesthetists under the superintendence of a medical practitioner and in country hospitals this practice has prevailed for years. Doctors have told me they would rather have a good anaesthetist than another medical man, and the famous surgeons – the Mayo brothers – will have no anaesthetist but a trained nurse.¹⁷⁹

However, in the case of anaesthesia, this was an area of expanded nursing practice which was gained, and then lost by New Zealand nurses. Prior to World War I, unpaid or minimally paid surgeons-in-training were often recruited to administer anaesthesia, however, in time nurses were seen as a better and acceptable alternative, as they would offer stability over time and the feminine “gentle touch”.¹⁸⁰ Following World War I, medical practitioners began to claim this area of practice as a new specialty, and returning New Zealand nurse-anaesthetists found their skills were unwelcome. In the United States, in spite of the strengthening medical claim to anaesthesia practice in the military, World War II “served to institutionalize the nurse-anaesthetist role even further with the military clarifying the position and elevating the status of the nurse anesthetist.”¹⁸¹ Following World War II, nurse-anaesthetists in the United States developed a formal credentialing programme, a benchmark in advanced practice. They currently provide over 65% of all anaesthesia care in the United States.¹⁸²

¹⁷⁹ N.A., H-21, 22734, 21/10 Nurses acting as anaesthetists. Bigbee, 1996, 5. It is noted here that in the early 1900s all anesthesia at the Mayo Clinic was administered by nurses. Alice Magaw was a nurse-anesthetist at Mayo who evaluated and published an accounting of her work citing over 14,000 surgical cases without one anesthesia-attributable death.

¹⁸⁰ Bigbee, 1996, 5.

¹⁸¹ Bigbee, 1996, 6.

¹⁸² American Nurses Association. (1993). Advanced practice nursing: A new age in health care. Retrieved 3 October 1998 from <http://www.nursingworld.org/readroom/fsadvprc.htm>

McKillop's research on Native Health Nurses¹⁸³ also demonstrates how nurses working at a distance - in this case, in rural and remote areas of New Zealand – extended their practice beyond the limits of their narrow hospital training to encompass preventative care, health teaching, disease prevention, in addition to nursing the ill. Furthermore, in spite of directives that Native Health Nurses were to work sympathetically and cooperatively with the medical practitioners in their districts, and were in no way expected to diagnose and prescribe, the remote conditions under which the Native Health Nurses worked often required them to diagnose, treat and manage illnesses or accidents.

Peter's research on nursing in the home explores how place has the potential to restrict or enhance power and moral agency.¹⁸⁴ Drawing on Liaschencho, Peter notes, "place is important in shaping our identities and in fostering (or depleting) our sense of self and agency".¹⁸⁵ Certainly nurses working outside the rigid hospital hierarchy often demonstrated their own agency, diagnosing, treating, teaching, providing a range of health services and nursing care, and expanding their practice as required to meet the patients' needs. Such actions within the hospital would have not only been constrained, but would have been the cause for discipline and/or dismissal.

Advanced: Beyond single registration

In 1925, when Mary Lambie went to Canada in preparation for her role as public health nursing instructor for the planned University of Otago diploma programme, she saw how the Canadian system of nursing education, while still hospital-based, was evolving to a comprehensive approach. Her perception was that

Their whole system was largely different from ours in New Zealand at that time, and I felt they were talking a completely different language...The period of training was three years and covered much the same syllabus as in New

¹⁸³ McKillop, 1998.

¹⁸⁴ Peter, E. (2002). The history of nursing in the home: Revealing the significance of place in the expression of moral agency. *Nursing Inquiry*, 9(2), 65-72.

¹⁸⁵ Peter, 2002, 65.

Zealand, except that there was no separate obstetrical training; each nurse was required to have three months experience in obstetrics in her general training... .Further, as there was no separate training for nurses in mental hospitals, many of these hospitals had nurses from the main hospitals who were affiliated to them for a period of three months. Added to this was a new plan to give each pupil nurse some knowledge of public health nursing. Classes were held at the university and each nurse was expected to undertake two or three field visits with one of the public health organizations within a period of a month. This variety of experience made the training very comprehensive, but to my mind much was superficial knowledge. ...”¹⁸⁶

While acknowledging the similarities in the New Zealand and Canadian systems, her comments underscore her beliefs in single-focused (e.g. general hospital nursing, mental hospital nursing, maternity nursing) learning based on service. Following a three-year period as one of the two inaugural instructors at the Postgraduate School for Nurses, Mary Lambie became Director, Division of Nursing in the Department of Health in 1931, a post she held until 1950. While comprehensive programmes were being established in Canada and the United States in the 1920s, single-registration, apprentice-style programmes persisted and proliferated in New Zealand.

Typical of nurses of her time, Mary Lambie extended her general nurse training by undertaking the Plunket course (infant care) in 1924, after eleven years in practice and just prior to her departure to Canada. She commented on the value of “fresh interests and mental stimulus” she found in the Plunket training, and believed this applied to other nurses.¹⁸⁷ On her return from Canada, she qualified in midwifery training at Wellington Hospital – another service-oriented course. The pattern had been set early. Grace Neill, the first Assistant Inspector of Hospitals, Asylums and Charitable Institutions expressed the view, “in the future, no nurse would be eligible for the higher ranks of the profession unless she held the certificate of registration

¹⁸⁶ Lambie, M. (1956). *My story: Memoirs of a New Zealand nurse*. Christchurch: N.M. Peryer Ltd., 38-39.

¹⁸⁷ Lambie, 1956, 32.

both in nursing and midwifery.”¹⁸⁸ And thus, for many decades, New Zealand nurses followed this pattern as a way of “advancing” their knowledge and skill.

Advanced: Educators and managers

The fifth year of the University of Otago’s Diploma in Nursing, and the subsequent Postgraduate School for Nurses’ programme, was designed to prepare nurses,

to fill positions as administrators, tutor-sisters, ward sisters and public health nurses (district nurses, school nurses, tuberculosis nurses) so that the qualified nurse undertaking it shall be carried to a stage higher in the technical side of her work, as well as being taught principles of education and methods of teaching, thus giving a better service to the community as a whole.¹⁸⁹

In her memoirs Mary Lambie comments:

When the school first began, Miss Moore and I thought it would take us ten years to see its effect. I think it did take that time, but when I retired the school had been in operation for twenty years and by far the majority of the senior nurses in the Dominion (New Zealand) were former students.¹⁹⁰

Kinross observed that, “by the 1920s the pattern was set for a system of three-year apprentice-type training, followed by a one-year postgraduate education for a select few, which was to remain the predominant pattern for nursing in New Zealand for fifty years”.¹⁹¹

¹⁸⁸ Neill, J.O.C. (1961). *Grace Neill: The Story of a Noble Woman*. Christchurch: N.M. Peryer Ltd., 50-51.

¹⁸⁹ Original course information 1929. Private papers, E.B. Salmon, cited in Rodgers, 1985, 85.

¹⁹⁰ Lambie, M. (1956). *My story: Memoirs of a New Zealand nurse*. Christchurch: N.M. Peryer Ltd, 129.

¹⁹¹ Kinross, N. (1984 a). Nursing education in New Zealand: A developmental perspective. *International Journal of Nursing Studies* 21(3), 195.

Nursing education and administration were primary areas of post-registration preparation at SANS,¹⁹² and were also the areas for which degree preparation was again mooted in the 1950s. Speaking at the Student Nurses' Conference in 1954, Flora Cameron, Director of the Division of Nursing in the Department of Health noted,

We must at some time consider university education for nurses. It would not be possible to change our method of basic training, but I do think we could plan for university courses in nursing education, nursing administration and public health nursing at degree level.¹⁹³

This was consistent with the development of nursing in other countries as well, where, up until mid-twentieth century, with the exception of public health nursing, further nursing education focused on “functional” specialisation as opposed to clinical practice development or specialisation.¹⁹⁴

Nursing administrators and teachers were in positions of leadership and had greater freedoms, similar to nurses who practiced at a distance from direct supervision. They therefore were seen as being both “advanced” and deserving of further education. Their leadership then, perhaps contributed to the perpetuation of the view that clinical practice, *per se*, and particularly clinical practice within the hospital, did not require further education. Other factors also contributed to a neglect of clinical practice development. These included conservative attitudes to women's roles, the image of nursing, the hospital hierarchy, reliance on students to provide nursing service, and a

¹⁹² NA, SANS, 7/12. A number of courses relating to education and administration were offered, e.g. Diploma in Administration and Teaching in Obstetrical Nursing 1948 – 1962; Diploma in Administration and Teaching in Paediatric Nursing 1957-1960; Diploma in Hospital and Nursing School Administration 1948 – 1957, then split to Diploma in Administration of Hospital Nursing Service and Diploma in Administration of School of Nursing; Diploma in Administration and Teaching of Public Health Nursing.

¹⁹³ Cameron, F.J. (1954). Trends in nursing overseas. *The New Zealand Nursing Journal*, August, 133.

¹⁹⁴ Bigbee, J. (1996). History and evolution of advanced nursing practice. In Hamric, A. Spross, J. & Hanson, C. (1996). *Advanced nursing practice: An integrative approach*. (pp.3-24). Philadelphia: W.B. Saunders Company, 14.

belief that experience equaled clinical expertise also contributed to a neglect of clinical practice and a gap between nursing leaders and the “rank-and-file”.

Advanced by technical specialty

In their research into post-basic nursing education in New Zealand, King, Fletcher and Callon noted that, as far as they could ascertain, the first clinically-oriented post-registration courses commenced in 1948.¹⁹⁵ That year, Otago Hospital Board instituted a course in neuro-surgical nursing, and a plastic surgery nursing course was established by the North Canterbury Hospital Board. Over the next twenty years, at least nine other courses, ranging from operating theatre, cardio-thoracic, neonatal and intensive care nursing courses, were established by various hospital boards.¹⁹⁶

According to King et al., the primary reasons nurses gave for undertaking these courses included improving nursing knowledge and skills, increasing confidence and self-development, and providing an opportunity for change. As the same authors point out, all these courses were extensions of the apprenticeship model, with no formal link to a tertiary educational institution, and with students making “a significant contribution to the provision of nursing service in the units concerned”.¹⁹⁷

This marked the beginning of specialty nursing as “advanced nursing”, as these nurses were regarded by physicians, fellow nurses and the community, as possessing more complex knowledge and skills, exercising greater responsibility, and were often accorded greater recognition.¹⁹⁸ In her historical study of the inception and rapid development of coronary care units (CCU) in the United States in the 1960s, Arlene Keeling describes how the change in the nurse’s role in these new settings expanded

¹⁹⁵ King, B.E., Fletcher, M.P. & Callon, L.G. (1982). *Post-basic nursing education in New Zealand*. Wellington: Department of Health, 12.

¹⁹⁶ King, Fletcher & Callon, 1982, 12.

¹⁹⁷ King, Fletcher & Callon, 1982, 13.

¹⁹⁸ Albarran, J & Fulbrook, P. (1998). Advanced nursing practice: An historical perspective. In G. Rolfe & P. Fulbrook. *Advanced nursing practice*. Oxford: Butterworth Heinemann, 12.
Roy, Sr.C. & Martinez, C. (1983). A conceptual framework for CNS practice. In A.B. Hamric & J. Spross. *The clinical nurse specialist in theory and practice*. (pp. 3-20) Orlando, FL: Grune & Stratton, 12.

their scope of practice, and while they did not become collegial equals with physicians, they did achieve a new level of autonomy, respect and status.¹⁹⁹ Keeling quotes Lawrence Meltzer, one of the pioneers of coronary care, when he noted

Until World War II even the recording of blood pressure was considered outside the nursing sphere and was the responsibility of the physician. As late as 1962, when coronary care was introduced, most hospitals did not permit their nursing staff to perform venipunctures or to start intravenous infusions. That nurses could interpret the electrocardiograms and defibrillate patients indeed represented a radical change for all concerned.²⁰⁰

With the development of the CCU, “nurses...now stepped over the nursing practice domain line into the realm of scientific medicine and ‘cured’ the patient’s arrhythmias – in dramatic lifesaving moments. In doing so, they set the stage for continued expansion of nursing’s scope of practice.”²⁰¹

By the 1970s nurses were increasingly defining themselves according to their specialty area of practice. Miller notes that the 1972 NZNA Conference approved changes to the constitution which permitted the formation of special interest sections and, by 1979, forty-four such groups had been established.²⁰² Parallel developments in American nursing led the American Nurses’ Association in 1980 to declare “specialization in nursing is now clearly established”, and to assert that “specialization is a mark of the advancement of the nursing profession”.²⁰³ In New

¹⁹⁹ Keeling, A. (2004). Blurring the boundaries between medicine and nursing: Coronary care nursing, circa the 1960s. *Nursing History Review* 12, 139-164.

²⁰⁰ Keeling, 2004, 156.

²⁰¹ Keeling, 2004, 159.

²⁰² Miller, N. (1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses’ Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses’ Association.

²⁰³ Bigbee, J. (1996). History and evolution of advanced nursing practice. In Hamric, A. Spross, J. & Hanson, C. (1996). *Advanced nursing practice: An integrative approach*. (pp.3-24). Philadelphia: W.B. Saunders Company, 4.

Zealand Dame Margaret Bazley commented, “it was the age of qualifications... There used to be a thing of collecting qualifications.”²⁰⁴

Over time, the knowledge and skills of a specialty may become extended to the profession at large. For example, hospital-focused general nursing gradually came to include aspects of maternal-child health, mental health and community health, growing a broader foundation for “basic” nursing education, and thus redefining specialist knowledge. Equally, specialisation legitimatised the use of knowledge and skills originally seen as the province of the physician. Coronary care nurses were taught interpretation and emergency treatment of various arrhythmias. Early intensive care and coronary care nurses developed physical assessment skills, particularly auscultation of heart and lung sounds, and abdominal assessment. Aspects of their once-specialist knowledge and skills have passed into the common curricula of pre-registration nursing education and, in a sense, these extensions may be said to advance professional practice.

Advanced by experience, formal education, clinical focus and title

In 1976, NZNA published its *Policy Statement on Nursing in New Zealand: New Directions in Post-Basic Education*,²⁰⁵ which proposed career alternatives for nurses, including the elaboration of several professional roles, their titles and the preferred preparation for such roles. This policy statement grew from the decisions, possibilities and uncertainties of the time. The 1969 *Review of Hospital and Related Services in New Zealand*²⁰⁶ had identified serious problems in the health services. These included the dangers inherent in staffing hospitals largely with students and the inadequate preparation of nurses for the breadth and complexity of required patient care both in and out of hospital. With the 1971 Carpenter Report recommending that nursing education be established “in an appropriate educational setting” and that the

²⁰⁴ Interview with Dame Margaret Bazley, 18 May 2000.

²⁰⁵ New Zealand Nurses' Association. (1976). *Policy statement on nursing in New Zealand: New directions in post-basic education*. Wellington: Author.

²⁰⁶ Department of Health. (1969). *A review of hospital and related services in New Zealand*. Wellington: Author.

“existing hospital schools be phased out”,²⁰⁷ the organization of nursing services, so long dependent on student nurses was once again, a matter for serious concern. Then, in 1974, the wide scope of the deficiencies in pre- and post-registration nursing education, professional development and the utilization of nurses across the health services was underlined in the fifty-nine recommendations outlined in a report of the Board of Health’s Committee on Nursing Services.²⁰⁸

Given impetus by the massive change required in nursing education and nursing services, the NZNA *Policy Statement on Nursing in New Zealand: New Directions in Post-Basic Education* (1976) sought to accelerate the rate of transfer of pre- and post-registration nursing education to the general system of education in technical institutes and universities, including the establishment of a pre-registration nursing degree programme, and the development of clinical career structures in practice, management, and education. The document drew heavily on American nursing literature relating to the development of clinical nurse specialists and, in particular, a paper presented by Virginia Cleland at the 1972 American Nurses’ Association Convention.²⁰⁹ NZNA’s proposal detailed a similar hierarchy of career alternatives titled *Nurse, Nurse Practitioner, Nurse Clinician, Nurse Teacher* and *Nurse Manager*, and noted “a few nurses may choose to seek a position as *Nurse Researcher*.”²¹⁰

The *Nurse* was essentially the staff nurse, while the *Nurse Practitioner* was defined as a nurse holding a post-basic diploma or degree with an “identifiable clinical component” who functioned as a charge nurse.²¹¹ Thus, these charge nurses/ *Nurse Practitioners* would be responsible for clinical ward management, as well as elements of direct patient care, and would “demonstrate advanced competence in one of the

²⁰⁷ Carpenter, H. (1971). *World Health Organization assignment report*. Wellington: Government Printer.

²⁰⁸ New Zealand Board of Health. (1974). *Board of Health report series, No. 23: An improved system of nursing services in New Zealand*. Wellington: Author.

²⁰⁹ Cleland, V. (1972). Nurse clinicians and nurse specialist: An overview. In *Three challenges to the nursing profession: Selected papers from the ANA convention*. (pp.13-25). American Nurses’ Association. Cleland proposed the terms and a hierarchy of nurse, nurse practitioner, nurse specialist, and nurse clinician.

²¹⁰ New Zealand Nurses’ Association, 1976, 17.

²¹¹ New Zealand Nurses’ Association, 1976, 20.

major clinical areas e.g. community health nursing, maternal and child health nursing, medical/surgical nursing, mental health nursing”.²¹²

The *Nurse Clinician* was described as a Nurse Practitioner who has attained,

a degree or graduate diploma with a clinical focus. The term nurse clinician is utilized when referring to an expanded role which is dependent upon the utilization of broad cues, including those from physical assessment, health history taking, and the natural and behavioural sciences..... The setting in which the nurse (clinician) works varies between hospital and community and the time dimension of the nursing contact may extend throughout the acute and rehabilitative phase of a person’s illness.²¹³

Other pathways for a Nurse Practitioner included progression to *Nurse Teacher* or *Nurse Manager*.²¹⁴

In comparing these definitions with the Nursing Council’s 2001 definition of advanced nursing practice, some similar emphases are apparent. While none of the roles in the NZNA policy statement refer to advanced nursing practice, *per se*, the *Nurse Practitioner* is said to demonstrate “advanced competence”, functioning “at a higher general level than the nurse”. The *Nurse Clinician* refers to an “expanded role”. All roles refer to further education, but none refer to research utilization. The paper gave only brief mention to the role and preparation of the *Nurse Researcher*.

This proliferation of titles was most likely a reaction to the incipient loss of the hospital nurse training programmes, with their hierarchy of students and relatively few fully-trained staff. Judith Christensen comments on the enormous change in the role of the registered nurse working in the hospital with the transfer of nursing education from the apprenticeship system to the general education system:

²¹² New Zealand Nurses’ Association. 1976, 31.

²¹³ New Zealand Nurses’ Association. 1976, 22.

²¹⁴ New Zealand Nurses’ Association, 1976, 25.

The traditional reliance on employee students to provide much of nursing's work had led to a strongly hierarchical organization in which nursing was described as a list of tasks and duties.... The registered nurses acted largely in a supervisory capacity. They, in turn, were supervised by the charge nurses, and they, by their supervisors, and so on. Now the staff nurse was to be the 'doer' of the nursing work-force with the work organized in a more holistic, patient-centred way. As the change continued throughout the seventies and early eighties, the lack of an articulated theoretical framework upon which to shape this new role became increasingly apparent.²¹⁵

A range of theoretical frameworks was explored in nursing education in the ensuing years. However the NZNA proposal, which included definitions of nursing; the notion of dependent, independent and collaborative judgments; and the hierarchy of titles and roles, suggests that for most nurses at this juncture, the transition from "supervisor of students" or supervisor of other nurses to "practitioner" was a leap of understanding.

In 1984, when the NZNA published *Nursing Education in New Zealand: A Review and a Statement of Policy*,²¹⁶ it was noted that,

The career structure for the clinical nurse, as outlined in this document, is largely unchanged since the policy statement in *New Directions* (1976). Nursing in New Zealand remains as bereft of nurse clinicians and nurse consultants as it was at that time.²¹⁷

Advanced Diploma in Nursing: Repeating history

Following the establishment of the first nursing diploma programmes, and timed with the closure of SANS, new post-registration programmes were established in "selected

²¹⁵ Christensen, J. (1990). *Nursing partnership: A model for nursing practice*. Wellington: Daphne Brassell Associates, 10, 1.

²¹⁶ New Zealand Nurses' Association. (1984). *Nursing Education in New Zealand: A Review and a Statement of Policy*. Wellington: Author.

²¹⁷ NZNA, 1984, 39-40.

and well-established technical institutes schools of nursing.”²¹⁸ The first one-year Advanced Diploma in Nursing (A.D.N.) programmes commenced in 1979 in Auckland, Wellington and Christchurch, and then in Hamilton in 1980. It was argued that regionalisation of post-registration programmes would improve accessibility. This was certainly true for nurses within those regions, but as the programmes were not available through any distance-mode arrangement, nurses in smaller cities and rural areas did not have significantly improved access.

A focus of the A.D.N programmes was for “increased emphasis on their clinical content—the aim being to prepare advanced practitioners.”²¹⁹ With this direction, the A.D.N.s provided “a common core module of advanced nursing studies”,²²⁰ for example, nursing theory, social and biological sciences, not unlike the Postgraduate School for Nurses/SANS. The remainder of the year focused on a clinical area: community health, medical-surgical, maternal and child health, midwifery or psychiatric nursing. Unlike SANS however, the A.D.N.s did not offer programmes to prepare nurse educators or nurse administrators.

In a sense, these programmes were an anachronistic compromise. With nursing education transferred to technical institutes, and post-registration degree programmes established within Massey and Victoria universities, it would have been more in keeping with the recommendations of the Carpenter Report to have developed largely distance-based, undergraduate degree programmes designed to prepare nurses in clinical specialties, health system management and nursing education. However, a conservative view in nursing persisted. Nurses seeking to complete a post-registration degree in nursing received less than one year credit for the combination of either a hospital certificate or technical institute diploma, plus an A.D.N. Indeed, as Dr. Nan Kinross noted as early as 1984,

²¹⁸ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 76.
Bazley, M. (1978). Post-basic nursing education in technical institutes. *New Zealand Nursing Journal*, 71(8), 25. (This article is the text of a circular letter from Margaret Bazley, then Director, Division of Nursing, Department of Health.)

²¹⁹ Burgess, 1984, 76.

²²⁰ Bazley, 1978, 25.

it is true that the present system of a three year basic nursing programme, followed by a one-, two- or three-year post-basic programme seems a long and arduous road to the two qualifications required to be a nurse, and to advance to the next professional step on the ladder.²²¹

Expanded, extended, specialized and advanced: A contemporary view

The contemporary concept of advanced nursing practice is defined in many ways across the nursing literature. As recently as 1997, the United Kingdom Central Council for Nursing (UKCC) concluded, “there are neither agreed definitions of advanced practice nor criteria against which standards for advanced practice can be set.”²²² One point of agreement is the focus on clinical practice. The American Association of Colleges of Nursing (AACN) refers to the advanced practice nurse as “any nurse prepared at the master’s degree level to provide direct client care.”²²³

Implicit in the ICN definition and characteristics of advanced nursing practice noted in Chapter 1 are three components: specialization, expansion and advancement. The American Nurses’ Association in its 1995 Social Policy Statement describes these components:

Specialization is concentrating or delimiting one’s focus to part of the whole field of nursing. Expansion refers to the acquisition of new practice knowledge and skills, including knowledge and skills that legitimize role autonomy within areas of practice that overlap traditional boundaries of medical practice. Advancement involves both specialization and expansion and is characterized by the integration of a broad range of theoretical,

²²¹ Kinross, N. (1984). Nursing education in New Zealand: A developmental perspective. *International Journal of Nursing Studies* 21(3), 199.

²²² Rolfe, G. & Fulbrook, P. ed.(1998). *Advanced nursing practice*. Oxford: Butterworth-Heinemann, xiii.

²²³ American Association of Colleges of Nursing. (1996). *The essentials of master’s education for advanced practice nursing*. Washington, DC: Author, 12.

research-based, and practical knowledge that occurs as part of graduate education in nursing.²²⁴

In New Zealand, Nurse Practitioner is the title given to a particular “innovative role for registered nurses working at an advanced level”.²²⁵ Launched in August 2001 at a conference sponsored jointly by the Ministry of Health and the Nursing Council of New Zealand, the criteria and competencies for endorsement as a New Zealand Nurse Practitioner with prescribing rights are commensurate with the ICN definition and characteristics.

In 2002 the Australian Nursing Council and the New Zealand Nursing Council agreed to collaborative development of the Nurse Practitioner role, and subsequently co-sponsored a Nurse Practitioner Standards Project.²²⁶ This research project, completed in 2004, provided a report on the status of the development of Nurse Practitioners in both countries. An agreed description of the “core role” of the Nurse Practitioner in Australia and New Zealand was developed, including a set of core competency standards, education standards for accreditation of programmes preparing practitioners; and a process for later evaluation and review of the role and standards. The report recommended that the following definition for the Nurse Practitioner be adopted in the two countries.

A nurse practitioner (NP) is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession’s values, knowledge, theories and

²²⁴ Hamric, A. (1996). A definition of advanced nursing practice. In Ann B. Hamric, Judith A. Spross & Charlene M. Hanson, ed. *Advanced nursing practice: An integrative approach*. (pp.42-55). Philadelphia: W.B. Saunders, 46.

²²⁵ Ministry of Health. (2002b). *Nurse practitioners in New Zealand*. Wellington: Author, 1.

²²⁶ Australian Nursing and Midwifery Council. (2004). *The Nurse Practitioner standards project: Report to the Australian Nursing and Midwifery Council*. ACT: Author.

practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorized to practice.²²⁷

Conclusion

An examination of New Zealand archival material and nursing literature of the last century reveals advanced nursing referring to a diverse range of circumstances. These connotations of “advanced” have included:

1. Nurses with higher education;
2. Nurses with more than one type of registration;
3. Nursing outside the hospital walls, e. g. community nurses;
4. Nurse educators and administrators;
5. Specialty nursing, especially a technical specialty;
6. A higher position within a hierarchy of nursing titles; and most recently
7. An expert, masters-prepared clinical practitioner with expanded and nursing specialist knowledge and skills.

The conceptualization of advanced nursing as the clinical practitioner, rather than being more broadly applied to include nurse educators and nurse administrators, is a shift in emphasis which re-emerged in New Zealand in the 1990s. However, elements of each of the first five earlier connotations of advanced nursing may be found in the descriptions of “advanced nursing practice” and the Nurse Practitioner evolving in the late 1990s/early 2000. Higher education is certainly paramount. The first issue of the Nursing Council *Framework, Guidelines and Competencies for Post-Registration Nursing Education* noted that “advanced nursing practice programmes are at level 8 on the NZQA (New Zealand Qualifications Authority) framework or at postgraduate level.”²²⁸ The document also pointed out that,

²²⁷ Australian Nursing and Midwifery Council, 2004, 3.

²²⁸ Nursing Council of New Zealand. (1998). *Framework, guidelines, and competencies for post-registration education*. Wellington: Author, 17.

some registered nurses currently practicing will be considered by their peers to demonstrate advanced nursing practice. These nurses may have the clinical expertise required, but may not yet have the academic qualifications.²²⁹

Further emphasis on education, as well as a nod to hierarchy, is evident in the Nursing Council's 2001 publication, *The Nurse Practitioner: Responding to health needs in New Zealand*. It calls the "Nurse Practitioner: The highest level of clinical expertise and academic preparation".²³⁰

Initially, the contemporary notion of advanced nursing would seem to have no historical reference to "more than one type of registration". In the 1970s and 1980s, "comprehensive" nursing education replaced general, maternity, general and obstetric, psychiatric, psychopaedic nursing education and single registration of New Zealand nurses. The Nurses' Amendment Act 1990 provided for "direct entry" midwifery education - enabling one to become a registered midwife without having first been a registered nurse - and restored the legal provision for midwives to practice autonomously.²³¹ The path to midwifery registration, or from one type of nursing registration to another, and "advanced nursing", are no longer synonymous. However, today, the officially recognized advanced practice nurse, the Nurse Practitioner, does require additional credentialing by the Nursing Council, not dissimilar to another registration.

Advanced nursing practice has been described as within "a specific scope of practice,"²³² the practitioner specialising in one area of nursing practice.²³³ However,

²²⁹ Nursing Council of New Zealand, 1998, 11.

²³⁰ Nursing Council of New Zealand. (2001b). *The Nurse Practitioner: Responding to health needs in New Zealand*. Wellington: Author, 9.

²³¹ Papps, E. & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: A Foucauldian perspective*. Palmerston North: The Dunsmore Press, 136-137. In New Zealand, the 1904 Midwives Act, passed three years following statutory registration of nurses, provided for midwife registration, and established training institutions. Midwifery remained separate from nursing until the 1925 Nurses and Midwives Registration Act. Papps & Olssen, 1997, 125.

²³² Ministry of Health. (2002b). *Nurse practitioners in New Zealand*. Wellington: Author, 5.

not all specialty practice is advanced. In the evolving discourse and development of advanced nursing practice, Judith Christensen sought to clarify the relationship of specialty nursing to advanced nursing.²³⁴ She argued that there is a key difference in the level of practice for the advanced practitioner, drawn from the practitioner's higher level of nursing education, demonstrating clinical scholarship, critical analysis of complex health situations, clinical leadership and a nursing orientation "even when working within...overlapping boundaries with medicine".²³⁵

In her introduction to *The Nurse Practitioner: Responding to health needs in New Zealand (2001)*, Judy Kilpatrick, then Chair of the Nursing Council, observed that the educational preparation of nurses in New Zealand is "ideally suited to the move towards a more health-focused and population-focused health and disability sector", and goes on to suggest that Nurse Practitioners will lead this change towards primary health care.²³⁶ It remains to be seen whether the Nurse Practitioner (NP) will be significant in the delivery of primary care, (outside the hospital walls), however it is clear that the NP is intended to practice with greater autonomous scope. Some suggest that advanced nursing practice is reclaiming lost autonomy and roles which had been present in colonial New Zealand.²³⁷ To a large degree, this is romanticising the past. However, there is an integrity of nursing practice which is a consistent stream; and to borrow from the T.S. Eliot quote which opened this chapter, nursing present and nursing past, are both contained in nursing future.

In New Zealand, at the turn of the 21st century, what was newest in the view of advanced nursing was the focus on the clinical practitioner, who, through master's degree preparation, develops advanced practice characterized by the integration of an expanded range of practical, theoretical and evidence-based therapeutics to patient

²³³ Nursing Council of New Zealand, 2001a, 10.

²³⁴ Christensen, J. (1999). Integrating the terminology and titles of nursing practice roles: Quality, particularity and levelling. *Nursing Praxis in New Zealand*, 14(1), 4-11.

²³⁵ Christensen, 1999, 10.

²³⁶ Nursing Council of New Zealand. (2001b). *The Nurse Practitioner: Responding to health needs in New Zealand*. Wellington: Author, 7.

²³⁷ Richardson, S. (2002). Advanced nursing practice – Evolution or revolution? *Nursing Praxis in New Zealand*, 18(2), 33-41.

care. The title for this newly-recognised level of registered nurse has been drawn from international precedents and the New Zealand Nurses' Association's 1976 proposal.

It can be seen that today's conceptualisation of the advanced nurse incorporates key elements of the past. What purpose does the term "advanced" serve in its contemporary usage? With discourse defining "the realm of possibility...both constituting and dependent on historical, social and political framings,"²³⁸ what possibilities have been constituted in past and present discourses around "advanced" nursing practice?

This chapter has explored expressions of advanced nursing practice in New Zealand over time. Chapters Four through Eight examine New Zealand nursing history through the perspective of nursing's professional project. The following chapter traces the development of New Zealand nursing over the period 1860 to 1960, exploring the historical, social and political discourse about and around nursing, and further drawing out the "advance" of nursing, its professional project and the interplay of factors internal and external to nursing which influenced outcomes within the project.

²³⁸ Nelson, S. (1997). Reading nursing history. *Nursing Inquiry* 4,(4), 229.

Chapter 4: Nursing in New Zealand, 1860-1960 - The “First” 100 Years

If you think of time as an arrow, of course you think of the future as progress, going in one direction. But different people may desire different futures.²³⁹

Introduction

Whereas the previous chapter explicated understandings of advanced nursing practice in New Zealand in their historical contexts, this and the following four chapters examine New Zealand nursing history through the perspective of the professional project. This perspective on New Zealand nursing history reveals the critical interplay of the varying factors, both internal and external to nursing which effected outcomes within the project. Societal values, political power, population health needs and government policy influenced - and were influenced by the development of nursing's places of education and practice, its organisations, and policy entrepreneurs. As Skocpol noted, "groups or organizations have chosen, or stumbled into, varying paths in the past. Earlier 'choices' in turn, both limit and open up alternative possibilities for further change, leading toward no predetermined end."²⁴⁰

This chapter explores the historical development of nursing in New Zealand over its first one-hundred years: 1860-1960. As Great Britain and its other colonies, New Zealand in the late 1800s also saw demand for the “trained nurse” take hold and grow. Prior to this time nursing was the work of men and women within families and communities. It was in the latter part of the nineteenth century that nursing emerged as a developing profession. While this was due in large part to the powerful influence of Florence Nightingale, other influences such as the interplay of wars and scientific developments, changing social attitudes, and political and economic factors were intrinsic to the development of “modern nursing”.

²³⁹ Sardar, in Ezzell, C. (2002). Clocking cultures. *Scientific American*, Sept., 56-57.

²⁴⁰ Skocpol, T.(1984). Sociology's historical imagination. In T. Skocpol (Ed.). *Vision and method in historical sociology*. (pp.1-21). Cambridge: Cambridge University Press. 2.

In the decade 1900 to 1910, New Zealand nursing achieved the world first of statutory registration for nurses, developed a nursing periodical, established a national professional nursing organisation, and played a key role in founding the International Council of Nurses. However, the success of the Nightingale-trained nurse as an embodiment of virtuous womanhood ultimately limited possibilities for nursing. The role of woman, the threat to doctors'/male authority by nursing success, and the economic benefit of a nursing school to a hospital conspired to reduce nursing's autonomy, and supported the exploitation of nurses-in-training. The aspirations of New Zealand nurses for higher educational opportunities, in parity with other developing professions were thwarted over a long period – well past the time by which the United States and Canada had established bachelor and higher degrees in nursing.

These social, economic, political and ideological forces which shaped New Zealand nursing in its first one hundred years are examined. They provide a context against which the events in the later part of the twentieth century may be analysed - the campaign in the late 1960s and early 1970s to move nursing from hospital-based, apprentice-style training into mainstream tertiary education; the emergence of bachelor and higher degrees in nursing through the 1970s-1990s, and the development of the “advanced nurse practitioner” movement at the end of the 20th century.

Setting the scene for New Zealand's First Trained Nurses

The trained nurse became tantamount to the hospital nurse in the nineteenth century due to the revolutionary work of Florence Nightingale, and the scientific, socio-economic developments in the nineteenth century, that together changed hospitals from little more than abodes for the destitute and dying, to desirable community institutions. Interestingly, the history of New Zealand's first hospital is unclear. When the seat of the Colonial government was being re-sited in Wellington, the ship conveying Government papers from Auckland to Wellington, the “White Swan”, wrecked, and official papers and public documents were lost. However,

it would appear that by 1841 when the first Colonial Surgeon was appointed, some institution was in existence in Auckland into which Maoris, seamen and

some European patients were admitted, the Europeans only on the authority of the Colonial Secretary.²⁴¹

By 1846, the colonial government saw the need to establish four regional hospitals. That year, funds were granted for hospitals to be built in Auckland, Wellington, Wanganui, and Taranaki “for the treatment of sick and destitute Europeans, and free treatment for all Maoris”.²⁴²

Early New Zealand hospitals were established according to the same values and beliefs as for the English hospital tradition - that is, hospitals were for those who were too destitute or otherwise socially deprived to provide for their own care, either through family members, or by paying for medical or nursing care.²⁴³ Such hospitals were usually under the direction of a master and matron, who had no particular training, and any additional “nursing” staff were also untrained domestics. Convalescing patients also performed work necessary to the running of the hospital.²⁴⁴ The vast majority of people who required care received it at home.

Until the Medical Practitioners Act of 1868 which introduced compulsory registration of doctors, the roles of doctors, midwives, chemists and nurses often overlapped.²⁴⁵ Occasionally, doctors provided twenty-four hour nursing care for patients in their homes. On the other hand, missionary men and women, community healers, and nurses dispensed remedies, set bones and performed minor surgery.²⁴⁶

²⁴¹ Department of Health Annual Report, 1939, cited in New Zealand Department of Health. (1969). *A review of hospital and related services in New Zealand*. Wellington: Author, 9.

²⁴² New Zealand Department of Health, 1969, 9.

²⁴³ Chilton, M. (1968). *The genesis of the welfare state: A study of hospitals and charitable aid in New Zealand, 1877 – 1892*. Thesis, M.A., University of Canterbury, 3-5.

²⁴⁴ Baly, M. (1977). *Nursing*. London: B.T. Batesford Ltd, 37-45.
New Zealand Board of Health. (1974). *An improved system of nursing services for New Zealand*. Wellington: Government Printer, 12.
Rodgers, J., 1985, 7.

²⁴⁵ Belgrave, M. (1991). *Medicine and the rise of the health professions in New Zealand, 1860-1939*. (pp. 7- 24). In Linda Bryder, ed. *A healthy country: Essays on the social history of medicine in New Zealand*. Wellington: Bridget Williams Books Ltd.

²⁴⁶ Sargison, P. A. (2001). “Essentially a woman’s work”: A history of general nursing in New Zealand, 1830-1930. Ph.D. thesis, University of Otago, 10-48.

In 1860, the New Zealand “doctor” was scarcely more than the title, “with little but their pretensions to distinguish them from chemists, teeth-pullers and itinerant drug vendors”.²⁴⁷ With no standards of education, statutory regulation or other structures that defined responsibilities, “contemporary social and economic stereotypes of class and sex predominated over definitions of the nature of the work itself. Doctors were male, and nurses were female”.²⁴⁸

The Otago Medical School was founded in 1874; and until 1885 it consisted of a two-year pre-clinical school,²⁴⁹ which in 1905 was described as having “no library to speak of, no journals except the *Journal of Anatomy and Physiology* and no text later than...1893”.²⁵⁰ However given that the medical practitioner’s treatment was no more successful than his many other rivals in the health field – herbalists, homeopaths, hydrotherapists, chemists, masseurs, and nurses, “traditional mechanisms”²⁵¹ such as class and gender expectations served to establish medicine’s trust and authority.

A growing immigrant population led to increased demand for hospital facilities; and the growth of hospitals and nursing soon became intertwined. New settlements, goldmines, and military posts led to the establishment of many small hospitals.²⁵² By 1882, the four regional hospitals had increased to 37 provincial hospitals, and a number of other institutions related to “providing some relief to abandoned children,

²⁴⁷ Belgrave, 1991, 7.

²⁴⁸ Belgrave, 1991, 10.

²⁴⁹ New Zealand Department of Health. (1969). *A review of hospital and related services in New Zealand*. Wellington: Author, 17.

²⁵⁰ Carr, I. & Taylor, D.W. (1995). Physiology in the Otago Medical School: The John Malcolm letters. In L. Bryder & D. A. Dow. *New countries and old medicine: Proceedings of an international conference on the history of medicine and health*. (pp.229-235). Auckland: Pyramid Press.

²⁵¹ Larson, 1977, 22.

²⁵² Lambie, M. (1950). *Historical development of nursing in New Zealand*. Wellington: Department of Health.
Rodgers, 1985, 7.

the destitute or old”.²⁵³ In reality, the first provincial hospitals were little more than almshouses for the destitute, ill, and helpless.

This changed in the later part of the Victorian period, when shifting socio-economic forces, including charitable motives, the work ethic, and an awareness of financial opportunity led to development of multiple hospital systems in England, New Zealand, and other colonies.²⁵⁴ The growth of hospitals in the mid-to-late nineteenth century was also due, in part, to advances in science and medicine, such as a beginning understanding of the causes of infectious diseases, the use of antiseptics and anaesthetics in surgery, and the development of the stethoscope, mercury thermometer and x-rays.

Public hospitals included those established by central government, as well as hospitals established by local authorities. At the same time, “subscription”, or “private” hospitals also developed.²⁵⁵ “Throughout the provincial period, uneven distribution of hospital facilities became a feature of New Zealand spawned by unequal wealth and resources of the provinces”.²⁵⁶ Rivalry between neighbouring towns appeared to contribute to the proliferation in hospitals.

However, in spite of charitable impulses in establishing hospitals, conditions in the hospitals had not moved far from the almshouse. Rodgers describes conditions thus:

It was most difficult to find ‘steady and sober’ men to act as wardsmen- the duties being onerous, constant, and disgusting...At Auckland, for two shillings per day a patient was entitled to lie on a vermin infested palliase...Convalescent patients were overtaxed with scrubbing and other

²⁵³ French, P. (1998). A study of the regulation of nursing in New Zealand 1901-1997. Thesis, M.A. Victoria University of Wellington, 43.

²⁵⁴ Ashley, J. (1976). *Hospitals, paternalism, and the role of the nurse*. New York: Teachers’ College Press.
Baly, M. (1986). *Florence Nightingale and the nursing legacy*. London: Croom Helm, 205.
Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul.

²⁵⁵ Burgess, 1984, 4.

²⁵⁶ Rodgers, 1985, 7.

onerous work, while the vegetable garden was flourishing from the steady supply of raw sewage...Provincial councils employed staff and administered hospitals. The remoteness of such councils from the hospitals conceptually and physically meant that everyday organisation was left to the master, mistress or untrained matron whose abilities were often questionable.²⁵⁷

Against this backdrop, the first Nightingale-trained nurses began arriving in New Zealand in the late 1870s and 1880s.

Miss Nightingale's Disciples

Prior to the establishment of the Nightingale Training School,²⁵⁸ nurses, whether master, mistress or matron, had “neither formal training nor class status” upon which to press demands for better conditions for patients or themselves.²⁵⁹ But due to Florence Nightingale’s resounding success over the British Army’s medical system in the Crimea, and the subsequent establishment of her training school at St Thomas’s Hospital, a model of nursing education, and support for health reform spread.²⁶⁰ Graduates of the Nightingale School were quickly in demand by other hospitals, and throughout the colonies.²⁶¹

Alongside their training in hygiene, antiseptic, and the administration of medicines and treatments, the “first generation” of Nightingale nurses had been trained as teachers, hospital managers and “disciples”, and they were expected to start new

²⁵⁷ Rodgers, 1985, 7.

²⁵⁸ Baly, 1977, 53.

²⁵⁹ Reverby, S. (1987b). A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research* 36(1), 6

²⁶⁰ Baly, 1977, 42-43.
Reverby, 1987b, 7.

²⁶¹ Godden, J. (2001). “Like a possession of the devil”: The diffusion of Nightingale nursing and Anglo-Australian relations. *International History of Nursing Journal*, 6(2), Retrieved 1/17/2003 from <http://proquest.umi.com/pdqweb?TS>
Bullough, V. & Bullough, B.(1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm, 114-115.
Rodgers, 1985.

training schools on the Nightingale principles.²⁶² Rodgers describes three early Nightingale disciples to New Zealand.²⁶³

Mary Lyons who trained at St Thomas Hospital came to New Zealand in 1879 to take up the position of Matron at Masterson Hospital. Annie Crisp, trained in the Nightingale ethos at Neatly Hospital in Southampton arrived in New Zealand in 1883, and one month later was appointed as Lady Superintendent at Auckland Hospital. Mrs Bernard Moore, who had apparently served under Miss Nightingale in the Crimea, was appointed Matron of Wellington Hospital in 1882. It was under Mrs Moore that Wellington Hospital established New Zealand's first nurse training programme in 1883.

The position of Inspector of Hospitals had been established in 1880 to enable the Government to exert some control over standards and the proliferation of hospitals. The position remained effectively unfilled until November 1882 as the first appointee died shortly after his appointment.²⁶⁴ Dr G. W. Grabham, New Zealand's second Inspector of Hospitals, who had had twenty-five years of experience in hospital administration in England, wrote in his 1884 report to the House of Representatives:

A very excellent system of nursing is in full operation at the Wellington and Auckland hospitals where well-educated ladies may be seen serving their apprenticeships with other probationers. Trained nurses from these schools will gradually become distributed in various parts of the colony. The example so set might with advantage be followed by others of the larger hospitals whose present nursing arrangements are not in accordance by any means with modern ideas.²⁶⁵

²⁶² Baly, 1977, 55.

Donahue, M.P. (1985). *Nursing the finest art: An illustrated history*. St Louis: C.V. Mosby.
Godden, J. (2001). "Like a possession of the devil": The diffusion of Nightingale nursing and Anglo-Australian relations. *International History of Nursing Journal*, 6(2), Retrieved 1/17/2003 from <http://proquest.umi.com/pdqweb?TS>

²⁶³ Rodgers, 1985, 11.

²⁶⁴ Department of Health, 1969, 10.

²⁶⁵ Department of Health, 1951 cited in Kinross, N. (1984). Nursing education in New Zealand: A developmental perspective. *International Journal of Nursing Studies* 21(3), p.193.

Having a nurse training system was seen as the means to bring cleanliness, order, and safety to hospitals. It was also economical. The salary of an “ordinary nurse” was twice that of a nurse-in-training.²⁶⁶ By 1895, Dr Grabham’s Annual Report noted that nurse training was then being conducted at Wellington, Auckland, Dunedin, and Waikato hospitals.²⁶⁷

The Nightingale revolution not only brought respectability to the work of nursing. In particular, Florence Nightingale designed nursing as a *female* “calling”. Nightingale nursing therefore provided well-to-do Victorian women with an opportunity to “do good work”, and enabled a growing number of middle class women a respectable means to earn a living. Hospitals were able to capitalise on these social movements and use nurse training as a means attracting and retaining staff in England and throughout the colonies.²⁶⁸

The Nightingale Revolution

“It is doubtful whether any woman’s story has been repeated oftener than that of Florence Nightingale.”²⁶⁹ Her accomplishments are remarkable. Within six months at Scutari, her nursing regime reduced the death rate in the military base hospital from forty-two percent to two percent.²⁷⁰ She campaigned for and won, a formal investigation on military health care, and published her own 800-page study, *Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British*

²⁶⁶ Chilton, 1968, 36-37.

²⁶⁷ French, P. (1998). A study of the regulation of nursing in New Zealand 1901-1997. Thesis, M.A. Victoria University of Wellington.

²⁶⁸ Rodgers, J. (1985). Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. Thesis, M.A., Massey University.

Sargison, P. A. (2001). “Essentially a woman’s work”: A history of general nursing in New Zealand, 1830-1930. Ph.D. thesis, University of Otago, 16.

Reverby, 1987b, 7.

Ashley, J. (1976). *Hospitals, paternalism, and the role of the nurse*. New York: Teachers’ College Press.

²⁶⁹ Donahue, 1985, 238.

²⁷⁰ Donahue, 1985, 243-245.

Army.²⁷¹ In this work she demonstrated her skill as a statistician, and an innovator in graphical statistical representation with her “coxcombs” charts. Her campaign was ultimately successful, and the British Army adopted a sanitary code, reconstructed barracks and hospitals accordingly, and developed improved procedures for gathering medical statistics. She established the first organised school for nurses at St Thomas Hospital. Her slim volume, *Notes on Nursing* (1859) was used as a text throughout Great Britain and its colonies, and was also translated into German, French, and Italian. To argue that Florence Nightingale was the first nursing “policy entrepreneur” would seem like something of an understatement.

The Nightingale Training School for Nurses opened in 1860 as an independent school financed by the Nightingale Fund. It was associated with St Thomas Hospital because the matron, Mrs Wardroper, was a friend of Miss Nightingale, and the medical officer, R.G. Whitfield were supportive.²⁷² Most London physicians, however, were opposed to the idea. “Out of 100 physicians queried, only four favoured the school.”²⁷³ The Senior Surgeon of St Thomas’s was perhaps typical in his view that “nurses are in the position of house-maids and need only the simplest instruction.”²⁷⁴

In spite of influential supporters Nightingale understood that given the hostility from the doctors, it was critical that the first trainees were successful—that is, provide a model of a working woman who would nevertheless fit within the Victorian view of womanhood. Expectations were unequivocal: “We require that a woman be sober, honest, truthful, without which there is no foundation to build. We train them in the habits of punctuality, quietness, trustworthiness, personal neatness”.²⁷⁵

²⁷¹ Donahue, 1985, 247.

²⁷² Baly, M. (1977). *Nursing*. London: B.T. Batesford Ltd, 53.

²⁷³ Donahue, 1985, 248.

²⁷⁴ Baly, 1977, 53.

²⁷⁵ Florence Nightingale, in Dean & Boulton, 1980 cited in Papps & Olssen, (1997). *Doctoring childbirth and regulating midwifery in New Zealand: A Foucauldian perspective*. Palmerston North: Dunmore Press, 124.

Early trainees were carefully selected on the basis of their education and moral standing. Throughout their one-year training, they lived in a supervised nurses' home furnished "with books, maps, music and flowers, and intended to give the pupils a background of culture and education....But more important, close supervision ensured that no breath of scandal touched the Nightingale ladies".²⁷⁶

In the nineteenth century, most education for the professions was provided by apprenticeship – arrangements which often required strong family connections and/or wealth.²⁷⁷ Louise Shaw²⁷⁸ has provided a New Zealand example of such arrangements for pharmacy apprenticeships. She noted that the intending apprentice, or his or her parents, were required to pay between £50 and £100 to the master chemist as a demonstration of commitment to the apprenticeship; and that at least prior to World War I, it was unusual for women to enter pharmacy without strong family connections.

Shaw's research, which explored women's participation in pharmacy between 1881 and 1939 describes how culturally-defined gender roles determined the opportunities for women in that field. While pharmacy was considered to be appropriate for women "as it required some skills perceived as 'feminine', such as neatness and accuracy",²⁷⁹ certain positions for women pharmacists were deemed inappropriate. For example, retail pharmacy was seen as more "masculine" because it was considered to be entrepreneurial, and therefore not suitable for women, while hospital pharmacy, because it was carried out in a more structured, hierarchical situation was therefore less-skilled and more appropriate for women. Also as Shaw points out, the "one-man" nature of the retail pharmacy probably suggested "sexual danger" in the situation of an older male pharmacist working with a younger woman apprentice. Those women pharmacists who did work in retail pharmacy generally worked alongside their husbands. "Their work in pharmacy generally went unnoticed and

²⁷⁶ Baly, 1977, 54.

²⁷⁷ Larson, 1977, 94.

²⁷⁸ Shaw, L. (1998). From family helpmeet to lady dispenser: Women pharmacists 1881-1939. *New Zealand Journal of History*, 32(1), 23-42.

²⁷⁹ Shaw, 1998, 23.

unopposed because it was perceived as an extension of traditional domestic responsibilities...’’²⁸⁰

While a legacy of the Nightingale system was the nursing apprenticeship, certainly no one would have imagined anything different in the nineteenth century for nursing as a female occupation. And for female nursing, the nurses’ home was also perhaps appropriate for the Victorian era. However, the home added to the rigid, rule-bound, twenty-four hour environment of the nurse-apprentices. By the early 1900s, when more educational and work opportunities were opening to women, such as teaching and clerical work,²⁸¹ “the Home with its emphasis on regulations, obedience, Bible classes, and chapel twice a day was no longer as appropriate as it had been...’’²⁸²

Nightingale’s experience in the Crimea demonstrated that medical treatments contributed less to patient outcome than that which she saw as the work of the nurse. In leaving the medical treatment as the domain of the physician, and in creating a system of nursing hierarchy, she anticipated that nursing would share power with medicine in the provision of health care. Reverby notes that in the Victorian era, such female networks helped to overcome the limitations of socio-economic life for women.²⁸³ However, the Nightingale military-style hierarchy prevented collegiality, and stunted the development of a nursing sisterhood.

Nightingale’s vision of nursing “linked her medical and public health notions to her class and religious beliefs”.²⁸⁴ While emphasising character development and sanitation, Nightingale also reflected the Victorian belief in separate spheres of activity for men and women, and the notion of womanly virtue. Thus, in spite of Nightingale’s impressive record of achievements, and the success of professional

²⁸⁰ Shaw, 1998, 26.

²⁸¹ Nolan, M. (2000). *Breadwinning: New Zealand women and the State*. Christchurch: Canterbury University Press, 36.
Griffin, R.H. (2004). *Abbreviated history of teacher education in the Auckland area*. Auckland: O’Griffy Publishing.

²⁸² Baly, 1986, 221.

²⁸³ Reverby, 1987b, 7.

²⁸⁴ Reverby, 1987b, 7.

nursing, these achievements were often reduced to “natural female” abilities which therefore required little training, remuneration or other recognition.

Grace Neill: New Zealand nursing’s first policy entrepreneur

Grace Neill is acknowledged as the visionary who enabled New Zealand to become the first country to enact statutory registration for nurses. A Scotswoman, Grace Campbell Neill came to New Zealand via Australia in 1893 to take up her appointment as Inspector of Factories. Two years later she was appointed New Zealand’s Assistant Inspector of Hospitals, Asylums and Charitable Aid.²⁸⁵ While she called herself “a non-descript combatant against drink, poverty, factory owners and the medical profession”, she was certainly not non-descript.²⁸⁶

A tall, red-headed woman, her unconventionalities included cigarette-smoking, then considered as a male prerogative. Her formidable character, determination, and personal magnetism enabled her, at the turn of the century to forge a successful career for herself within the almost exclusively male world of government bureaucracy.²⁸⁷

Grace Campbell had trained as a nurse at Kings College and Charing Cross Hospital in London, and was the Lady Superintendent of Pendlebury Hospital from 1877 to 1879.²⁸⁸ Following marriage to Dr. Channing Neill, and the birth of a son, she continued to work, and completed midwifery training in 1886.

The family moved to Australia later that year, but Dr. Neill died two years later. Grace Neill supported herself and son, initially through journalism and establishing her own typewriting business. In 1890, she helped establish a union for women

²⁸⁵ Sargison, P. (1993). *Notable women in New Zealand health*. Auckland: Longman Paul, 18.

²⁸⁶ Sargison, 1993, 17.

²⁸⁷ Sargison, 1993, 17.

²⁸⁸ Sargison, 1993, 18.
Tennant, M. (1978). Mrs. Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions. *New Zealand Journal of History*, 12(1), 4.

workers, and subsequently was appointed as a member of an Australian Royal Commission (1891) inquiry regarding the conditions in factories and labour shops.²⁸⁹

Following this, she held a number of temporary government positions, but in 1893, moved to New Zealand in search of a more permanent situation. In 1894, she was appointed New Zealand's first woman factory inspector. Her early success in this role, and her experiences in Australia saw her appointed to a commission of inquiry relating to charges of "cruelty and parsimony" against the North Canterbury Charitable Aid Board.²⁹⁰ In 1895, Dr. Duncan MacGregor, Inspector-General of Hospitals, Asylums and Charitable Aid, requested that Mrs. Neill be transferred to his department as Assistant-Inspector. Dr. MacGregor wanted a woman with "a very high degree of ability, knowledge and sympathy", as a "lady-assistant's help is indispensable to me for the purpose of getting full information..."²⁹¹ Certainly, Grace Neill's credentials were superior to most people of either gender.

Her work as Assistant Inspector of Hospitals, Asylums and Charitable Aid brought her into conflict with charitable aid boards, including a particularly public debate regarding her investigations into the Wellington Benevolent Trust. However, it did bring about the appointment of women to charitable aid boards.²⁹²

Subsequently Neill was able to turn her attention more to nursing. In 1899 Neill was granted a six-month leave to England.²⁹³ While there, Neill communicated with Ethel Manson Bedford-Fenwick, the founder of the Royal British Nurses' Association. Mrs. Bedford-Fenwick was a fervent believer in nurses being "registered in the same way as doctors", and of safeguarding the title "nurse".²⁹⁴

²⁸⁹ Tennant, 1978, 4.

²⁹⁰ Tennant, 1978, 6.

²⁹¹ Tennant, 1978, 7.

²⁹² Tennant, 1978, 9.

²⁹³ Rodgers, 1985, 24.

²⁹⁴ Baly, 1977, 67.

Both Bedford-Fenwick and Neill attended the International Council of Women, held in London in 1899. Indeed, Neill was asked to be a principal speaker in the Nursing Section of the Council meetings.²⁹⁵ She presented her paper, “Professional Training and Status of Nurses”, and along with nurses from around the world, debated the question of nursing registration.²⁹⁶ Within two years of her presenting this paper, the New Zealand Nurses Registration Act was passed. England did not achieve statutory registration until 1919.²⁹⁷

The move for registration was a worldwide phenomenon, developing from the emergence of the modern nurse.²⁹⁸ That New Zealand achieved this first in the world is largely due to the beliefs and efforts of Neill, “although she, herself, never claimed responsibility”.²⁹⁹ She had a major role in drafting the 1901 Nurses Registration Act, and following its passage, she carried full responsibility for its administration. She defined the nursing curriculum, drafted regulations for the conduct of the system of examinations, appointed examiners, and administered the register.

In 1906, Grace Neill retired. The previous four years had seen her develop the Midwives Bill, work with Premier Richard Seddon to achieve its passage, and then establish the St. Helen’s maternity hospitals and midwifery training. In spite of high maternal and infant mortality, opposition to midwifery training and the St Helen’s hospitals was marked. The many untrained midwives were threatened, but the most influential opposition came from doctors with private maternity homes who feared financial losses.

Tennant notes that Grace Neill’s appointment as first, an Inspector of Factories, and then Assistant-Inspector of Hospitals, Asylums and Charitable Institutions came at a

²⁹⁵ Tennant, 1978, 10.

²⁹⁶ Neill, J.O.C. (1961). *Grace Neill: The Story of a Noble Woman*. Christchurch: N.M. Peryer Ltd, 38.

²⁹⁷ Baly, 1977, 74.

²⁹⁸ Donahue, 1985, 373-4.

²⁹⁹ Rodgers, 1985, 25.

time when “the condition of New Zealand women” was being given attention.³⁰⁰ While Neill’s expertise and abilities were notable, her appointments were based on the perception of needing a capable *woman* for the job. Even though Neill was involved in the widest work of the Department, over time, as the Department became more complex, there was a “devolution of the omnicompetent woman inspector into director of nursing services”.³⁰¹ Nevertheless, she was highly successful. Her success was due not only to her expertise, the legitimate power of her position, but also due to her personality, and relationships with superiors. In winning achievements for nursing and midwifery, she improved health care for New Zealanders. She linked problems with solutions, and linked both to political or ideological winds. Surely she could be described as New Zealand nursing’s first “policy entrepreneur”.

Standards and professionalism versus womanly virtue

The 1901 Nurses Registration Act instituted the Nurses Register of New Zealand. The register included the name and address of each nurse, and where and when she trained. In order to be registered, the nurse needed to have attained the age of 23, and have successfully completed a three-year training programme and a final examination. Throughout the Act the nurse is referred to as “she”.

The construct of nurse-as-gentlewoman was well established, as Dr MacGregor, in his 1901 Annual Report noted:

The last few years have brought about a great change in the organisation of our hospitals. Formerly our hospitals were for the most part served by a mixed staff of male and female nurses. Gradually, this has altered, so that now in almost all our hospitals, large as well as small, the nursing staff consists of female nurses only, male nurses being still retained to help in the care of such cases as are unsuitable for females. This revolution has been part of a world-wide movement....For a long time numbers of well-educated women, filled with the enthusiasm of humanity devoted themselves to the noble career thus opened to them...now at the opening of the present century, we find the

³⁰⁰ Tennant, 1978, 15-16.

³⁰¹ Tennant, 1978, 15.

business of nursing has become a profession. As now organised the nursing profession has gradually been placed on quite another basis – the market value of labour.³⁰²

The relationship between nursing and Victorian womanhood was surely the key to the political support for the Nurses Bill. Contemporary beliefs about women’s “morally superior natures” and the dedication, respectability and womanliness of the “new” nurses convinced politicians of the appropriateness of registration in 1901, as similarly, these beliefs had contributed to the success of the campaign for women’s suffrage in 1893.³⁰³

Neill and MacGregor were primarily concerned about the standard of nursing. In the 1890s, hospital matrons, lacking a professional support group, often had little or no authority over the selection of nurse-trainees or management of nursing services.³⁰⁴ The management of hospitals was conflict-laden, biased and manipulative, and matrons were often too proud, too humiliated, or too intimidated to battle.³⁰⁵ Noting the growing abuses of the hospital-based training system, and the trustees, who interfered in “selection of probationers and the promotion of nurses”,³⁰⁶ MacGregor commented:

It is only in our larger hospitals that it has been found possible to give any systematic training to nurses, or to provide any satisfactory way of testing and certifying their efficiency by examination. In many hospitals, not merely are the probationers not properly taught, but there is a positive tendency, which is

³⁰² AJHR, 1901, H-22, 2.

³⁰³ Dalziel, R. (1977). The colonial helpmeet: Women’s role and the vote in nineteenth century New Zealand. *The New Zealand Journal of History*, 11, 112-123.
Rodgers, J. (1994). ‘A paradox of power and marginality’: New Zealand nurses’ professional campaign during war, 1900-1920. Thesis, Ph.D., Massey University, 66.

³⁰⁴ Rodgers, J. (1985). Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos. M.A. thesis, Massey University.

³⁰⁵ Rodgers, 1985, 16.
Sargison, P. A. (2001). “Essentially a woman’s work”: A history of general nursing in New Zealand, 1830-1930. Ph.D. thesis, University of Otago 80-97.

³⁰⁶ AJHR, 1901, H-22, 3.

encouraged on the score of expense, to have as many probationers as possible, who get no pay for a period, and often no regular instruction.³⁰⁷

Statutory registration was a further mechanism to ‘advance’ nursing in terms of professional status.³⁰⁸ These were the first steps in New Zealand nursing’s professional project. The trained nurse had gained respectability, created a market for her services, and achieved the special status of statutory registration. Perhaps the first connotation of “advanced nursing” was “trained nurse”, followed by “registered nurse”.

In New Zealand as in Britain, Australia and the United States, the legitimisation of “trained nursing” by the state in the form of statutory registration was seen as the means to establish standards of nurse training – overcoming the abuses being perpetrated by those boards, trustees, physicians (and a few matrons) who saw “their” school as an economically-expedient necessity, an instrument of currying political and personal favour, and as a bastion from which to wield power.³⁰⁹ However, in none of these countries did state registration eliminate patriarchal control, and many measures sought to be included in registration acts were lost.

While the 1901 Act prescribed a three-year apprentice training and a final certifying examination, in one of the few amendments to the bill, the number of required lectures was reduced from twenty-five to twelve across the three year programme.³¹⁰ The bill had also sought to set criteria for a hospital to meet in order to operate a nursing training programme. However, Parliament rejected this proposal and

³⁰⁷ AJHR, 1901, H-22, 4.

³⁰⁸ Nelson, S. (1999). Déjà vu and the regulation of nursing in Victoria. *Australian Journal of Advanced Nursing*, 16(4), 33.

³⁰⁹ Bunting, S. & Campbell, J.C. (1994). Feminism and Nursing: Historical perspectives. In P.L. Chinn. *Developing the discipline*. (pp. 181-195). Gaithersburg: Aspen Publishers.
Forsyth, S. (1995). Historical continuities and constraints in the professionalization of nursing. *Nursing Inquiry*, 2, 164-171.
Nelson, 1999.
Sargison, 2001, 93-97.
Witz, A. (1994). The challenge of nursing. In J. Gabe, D. Kelleher & G. Williams. *Challenging medicine*.(pp.22-45), London: Routledge, 27.

³¹⁰ Sargison, 2001, 113.

permitted nurses to be trained in any public hospital. The difficulties regarding the variable standards and size of hospitals, the quality and quantity of instruction and the range of clinical experiences available to students were frequently to resurface over a half-century. Additionally, the protection of the title “nurse”, as opposed to “trained nurse” or “registered nurse” was either lost, as in the United States,³¹¹ or not envisioned, as nurse was synonymous with woman.

While asserting the value of the registered trained nurse, the effect of the Act was to ensure that hospitalised members of the public were nevertheless, primarily cared for by untrained and partially trained probationers/student nurses. Rodgers reported that in 1909, out of the pool of nearly 750 trained nurses, public hospitals employed 183.³¹² The Act had established the hospital as the place of training, and in doing so, brought nursing more securely under medicine’s control, and ensured that nursing education was secondary to the business of providing hospital nursing care.

While “first-generation” Nightingale nurses were educated in hospital management, this aspect was progressively diluted, and was largely lost from the New Zealand curriculum.³¹³ The nurse was “servant of the hospital board”,³¹⁴ and assistant to the doctor. The responsibility of the ward sister (the trained nurse) was not to carry out nursing care, but to supervise others (the students). Doctors controlled the curriculum, providing the majority of the lectures – when nursing service demands did not lead to cancellation of scheduled classes.

Some have postulated that had nurses remained largely external to the hospital, nursing would have avoided medical domination.³¹⁵ Nursing appeared to have more

³¹¹ Bullough, V. & Bullough, B.(1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm, 138.

³¹² Rodgers, 1994, 69.

³¹³ Godden, 2001.
Wilson, K. (1998a). Professional closure: Constructing the image of New Zealand nursing 1880-1940. *Nursing Praxis in New Zealand*, 13(1), 14.

³¹⁴ Rodgers, 1984, 35-36.

³¹⁵ Ashley, 1976, 16-20.
Baer, E. (1985). Nursing’s divided house: An historical view. *Nursing Research* 34(1), 36.

legitimate authority in the model of “private duty” care, where an independent nurse was contracted by the patient or family to provide the nursing care of that patient within the hospital as in the United States; or where nurses were in autonomous practice as managers of their own private hospitals as in New Zealand. However, given the Nightingale legacy, gender roles of the period, and the power of the male medical establishment, this seems unlikely. Commenting on British and American settings at the turn of the twentieth century, Baer notes,

When nursing was external to the hospital it was dominated in England by Nightingale and in America by boards of philanthropic women. Nightingale and the American sponsors who copied her put nurses in dust caps, wrote the rules for the nurses’ living quarters, and in general, modeled nursing after their domestic staffs.³¹⁶

Furthermore, with the trained nurse recognised as the key to the success of the hospital and the expansion of physicians’ work and income, nursing training quickly lost its Nightingale-led independence. However the obedience and conformity of the Nightingale system remained. And as a female occupation, nursing became caught in the gendered order of work, organisations and professionalisation strategies.³¹⁷

Anne Witz, Celia Davies and others have explored the multiple streams that fractured nursing attempts at professionalisation. Patriarchy and the growing success of the assertion of medical dominance in health care, the ideology of domesticity, and the ideology of professionalism which led nursing leaders to ally themselves with

Wilson, K. (1998a). Professional closure: Constructing the image of New Zealand nursing 1880-1940. *Nursing Praxis in New Zealand*, 13(1), 16.

³¹⁶ Baer, 1985, 36.

³¹⁷ Davies, C. (1995). *Gender and the professional predicament in nursing*. Buckingham: Open University Press.

Hughes, L. (1994). Professionalizing domesticity: A synthesis of selected nursing historiography. In P.L. Chinn (Ed.), *Developing the discipline*. (pp.173-180). Gaithersburg: Aspen Publishers.

Melosh, B. (1982). *The physician’s hand: work, culture and conflict in American nursing*. Philadelphia: Temple University Press.

Nolan, M. (2000). *Breadwinning: New Zealand women and the State*. Christchurch: Canterbury University Press.

Witz, A. (1992). *Professions and patriarchy*. London: Routledge.

medicine and the state, all worked to limit nursing's autonomy. In State registration, New Zealand nursing had achieved legitimisation of its training and the performance of its work in the labour market. However its education and practice were controlled by the medical profession and the State. Reverby summarises the historical dilemma for nursing enshrined as women's work:

Thus nurses, like others who perform what is defined as "women's work" in our society, have had to contend with what appears as a dichotomy between the duty to care for others and the right to control their own activities in the name of caring. ...The duty to care, organized within the political and economic context of nursing's development, has made it difficult for nurses to obtain this moral and ultimately, political standing.³¹⁸

For women, duty, devotion to service and discipline were essential to claim a place as a professional. However, perhaps for most women in the late nineteenth and early twentieth century, being a "professional", or continuing in the waged nursing workforce was not a prime motivation. Women, particularly in this period, looked to their connections and social place with family, neighbours, and church; and nursing "resonated more with their identity as women"³¹⁹ and less with that as employee.³²⁰

Women actively embraced the gendered meaning of nursing for the ease with which it allowed them to create work identities that remained connected to their personal identities, despite their formal relationship to the world of productive work. Nurses created the boundaries that were, often simultaneously, both a source of their strength and a dam around their ambition.³²¹

³¹⁸ Reverby, 1987b, 5.

³¹⁹ D'Antonio, P. (1998). Rethinking the rewriting of nursing history. Retrieved 19 June 2003 from <http://www.nursing.upenn.edu/history/chronicle/s98/antonio.htm>

³²⁰ Sargison, 2001, 147-150.

³²¹ D'Antonio, 1998.

In the late 19th century and early 20th century, nursing's jurisdiction and professionhood grew. The social, economic and political forces related to Victorian belief in women's morally superior nature; and the dedication, place and economic benefit of the woman/nurse to the growing hospital industry helped to ensure public, power-elite and State support. However, achieving a place in society based on a "good woman's virtues" ultimately limited nursing's own control over its education, practice and its development.

The failed University of Otago diploma and the Postgraduate School for Nurses

In her 1971 address to the New Zealand Nurses' Association conference, President Enyth Holdgate used the metaphor of battle and treaty settlement in referring to the loss of the University of Otago Diploma in Nursing:

If 1901 was our finest hour, 1925 must stand out in black letters as the Waterloo of the nursing profession in New Zealand. The shelving of the five-year programme by Otago University must surely have been the blackest day for, although the establishment of the New Zealand Postgraduate School was a treaty substitution, I believe this set the nursing profession in New Zealand back half a century.³²²

The establishment of nursing education within mainstream tertiary education, "based on their own educational requirements and not on the service needs of hospitals"³²³ was to elude New Zealand nursing for over seventy years. As noted in the previous chapter, Hester Maclean's conservative views on nursing education, shared by many nurses, favoured experience and service over education. While apprenticeship as the means of education was being discarded in other professions by the 1920s, nurses by-and-large remained loyal to the system through which they came.³²⁴ Trained in the

³²² Holdgate, E. (1971). We have a unique opportunity now. (Extracts from the presidential address delivered at the New Zealand Nurses' Association Conference). *The New Zealand Nursing Journal*, June, 4.

³²³ Hughes, B. (1978). Nursing education: The collapse of the Diploma of Nursing at the University of Otago, 1925-1926. *New Zealand Journal of History* 12(1), 17.

³²⁴ Hughes, 1978, 21.

Nightingale ethos of obedience and conformity, many nurses were unable to embrace proposals for change.³²⁵ Rodgers summarises the voices and forces:

While for a brief period in its early history, New Zealand nurses held within their grasp a university education for both nurses in training and trained nurses, this was lost. Another programme arose which while giving practical voice to the increasing need for knowledge by nurses, deferred to the desires of those who controlled nursing. Hughes (1978) states that the “single-minded determination” shown by the TNA to see the establishment of advanced education for nurses contrasts with the hesitation shown by others. It might be said that the “single-minded determination” of the nurse leaders, Miss Maclean and Miss Bicknell, to maintain control over nurse training was in the end the deciding factor.³²⁶

This other programme, the “treaty substitution” was the Postgraduate School for Nurses, later renamed the School for Advanced Nursing Studies (SANS). The original SANS six-month programme evolved to a 9-month post-registration diploma programme. For 45 years, from its foundation in 1928, until the first post-registration degree programmes in nursing were established at Victoria and Massey universities in 1973, SANS was the only educational institute offering higher education in nursing in New Zealand. And like pre-registration nursing education, the Postgraduate School for nurses was controlled by the Department of Health.

A proliferation of programmes

Once it was established that a nursing school improved the care of the sick, there was a rapid proliferation of hospital training schools.Many of the hospital training school founders considered the trained hospital nurse as simply a substitute for the competent mother or neighbor who cared for the sick at home. Since the average housewife scrubbed her own floors and did the family washing, it was assumed that these and similar chores were part of

³²⁵ Rodgers, 1985, 78.

³²⁶ Rodgers, 1985, 91.

the work of the nurses. Students were paid little or nothing and had to work long and hard hours for their board, room, and what little instruction they received. Such practices allowed a hospital to be staffed very cheaply and to provide better nursing care than ever...this exploited the nursing students, but few people bothered to ask if such procedures might be harmful in the long run – it was enough to establish a nursing school.³²⁷

Describing the response to trained nursing in the United States, Bullough and Bullough note that when Nightingale-style schools were being established in the U.S. in the 1870s, the whole of the country had only 149 hospitals. Fifty years later, there were nearly 7000, and hospital beds had increased from 35,453 to 770,375.³²⁸ The growth in training programmes illustrates the way in which the provision of nursing staffing became dependent on having a nursing school as part of the hospital. Similarly, in New Zealand in the 1880s, there were thirty-seven provincial hospitals, with nursing training offered in four of these. By 1969, there were 62 schools of nursing offering 139 various nursing programmes. Thirty-one schools offered a general and obstetric programme; ten schools offered a three-year programme for male nurses; there were twelve psychiatric or psychopaedic programmes; forty-six offered the 18-month community nurse programme; and nineteen provided the 18-month maternity nurse programme.³²⁹

Prior to World War II, most nursing students began their nursing work without any prior instruction. Between 40 and 70 hours of theoretical instruction was provided over their three-year apprentice training. By the late 1940s, hospitals generally provided for a four to twelve week introductory period of instruction, but following this, most lectures occurred in the students' own time, after full days (or nights) on the wards. Gradually, the provision of study days became more common.

³²⁷ Bullough, V. & Bullough, B.(1979). *The care of the sick: The emergence of modern nursing*. London: Croom Helm, 132.

³²⁸ Bullough & Bullough, 1979, 133.

³²⁹ Department of Health, 1969, 41.

In the 1960s only 34.7 percent of the nursing staff across all hospital boards were registered nurses. The other 65.3 percent of care was provided by nursing students (43.7 percent) and aides.³³⁰ It is telling that in 1969 no hospital school of nursing actually had a budget for education.³³¹

The attrition rate of the programmes highlighted the serious flaws in the approach to both education and service. In 1970, the average attrition rate across all three-year programmes was 39 percent. Psychiatric and psychopaedic programmes had much higher rates of 61 percent and 57 percent respectively.³³² The apprenticeship system, with its advantages to the hospital board management and the Government, and the gendered construction of nursing, together ensured that the system endured long past its Victorian roots.

Moving ahead - falling behind

By the 1950s there was a resurgence of concern for both pre- and post-registration education. In the face of a nursing shortage, the struggle to ensure appropriate entry standards and adequate theoretical preparation within the apprentice programmes was renewed.

In 1956 the Nurses and Midwives Board instituted what was seen as a major curriculum change. However, this “major change” was the incorporation of maternity nursing in the basic three-year programme.³³³ Other more fundamental, pedagogical changes were merely recommendations. The Board recommended gradual introduction to clinical experience on the wards; recommended a minimum of 104 study days over a three year period; and advocated an “integrated body systems”³³⁴

³³⁰ NA, H, H1, I-22, 33385,1/4/1 Nursing – Information NZ and overseas 1949-68. AJHR, 1965, H-31, 52.

³³¹ Department of Health, 1969, 43.

³³² Carpenter, H. (1971). *World Health Organisation assignment report*. Wellington: Government Printer, 11.

³³³ Cameron, F.J. (1956). Address by Miss F.J. Cameron, OBE on the new curriculum: 1956 Conference of Training School Matrons. *The New Zealand Nursing Journal*, June, 111-115.

³³⁴ Kinross, N. (1984). Nursing education in New Zealand: A developmental perspective. *International Journal of Nursing Studies* 21(3), 193-199.

approach to teaching with the hope that this would provide linkage between “knowing how and knowing why”.³³⁵

While there was concern about nursing training, by and large the profession did not see a need for nurses to gain their pre-registration education in any way other than through the traditional apprenticeship programme. Miller notes that,

Following the demise of the Otago University programme in 1926 and the commencement of the Post Graduate School in 1928 there was no serious discussion on the need for university education for nurses for almost three decades.³³⁶

Miller does not comment on reasons for the professional organisation’s lack of dialogue on higher education, but the Depression, the Social Security Act 1938, and World War II would have had a great impact. Each contributed to a demand for nurses – indeed there was a prolonged nursing shortage from the late 1930s through the 1950s. World War II also brought further recognition for nurses, and praise for their courage and skill.³³⁷

Belich asserts that the global depression of 1929-1935 may have affected New Zealand more than Britain if exports, the cost of imports, and unemployment are all considered.³³⁸ Varying estimates for New Zealand unemployment during the height of the Depression range from twelve to forty per cent.³³⁹ The range in the figures occurs since data often referred to different groups, for example, only registered

³³⁵ Stevenson, A. F. (1997). Realities and rhetoric: General hospital nursing in New Zealand 1945 to 1960. M.A. thesis, Victoria University of Wellington, 79.

³³⁶ Miller, N.(1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses’ Association 1909-1983*(pp79-93). Wellington: New Zealand Nurses’ Association, 86.

³³⁷ Rogers, A. (2003). *While you’re away: New Zealand nurses at war 1899-1948*. Auckland: Auckland University Press.

³³⁸ Belich, J. (2001). *Paradise reformed: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press, 247.

³³⁹ Belich, 2001, 255.
King, M. (2003). *The Penguin history of New Zealand*. Auckland: Penguin Books, 347.

pakeha men, or all men. If women, Maori and unregistered male unemployed are included, the higher figure may be more accurate. The Depression forced SANS to close for the year 1931.³⁴⁰ This was also the year of the Hawke's Bay earthquake during which 256 people died. The earthquake destroyed the Napier Hospital and the new Nurses' Home, killing eight patients and eight nurses.³⁴¹

Government response to the Depression also led to the closure of two teachers' colleges and a number of small nursing schools; the loss of primary school for five-year olds; resulted in 1,200 teachers being unemployed; and caused a ten percent drop in secondary school students.³⁴² The Social Security Act 1938, which provided free hospital care for all, led to an increase in hospital beds and health services, although doctors succeeded in "undermining the intended free visits to general practitioners".³⁴³

These changes, in concert with expanded opportunities for work for young women, created a protracted shortage of nurses (nursing students). The expectation that once married, a woman would leave the paid workforce meant that higher education for nurses (women), was seen as unnecessary - perhaps even frivolous in the dark years of depression and war. Even as late as 1970, Dr. R.M. Williams, Vice-Chancellor of the University of Otago claimed that to provide an undergraduate nursing programme would be "ambitious, quite apart from the obvious hazards in a high loss rate through marriage..."³⁴⁴

The renewed call for degree preparation to be available in New Zealand was taken up at the 1953 New Zealand Nurses' Association Annual Conference. At that time, it was believed there were only three nurses in New Zealand who held an undergraduate

³⁴⁰ NA, SANS, 7/12 . SANS also closed during 1942.

³⁴¹ Conly, G. (1992). *A case history: The Hawke's Bay Hospital Board 1876-1989*. Napier: Hawke's Bay Area Health Board, 117-118.

³⁴² Belich, 2001, 260.
Wilson, K. (1997). Nursing on the home front during World War II: An essential service in New Zealand. (pp. 67-79). In Norma Chick, ed. *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery*. Palmerston North: Massey University, 67.

³⁴³ Belich, 2001, 262.

³⁴⁴ Williams, R. M. (1970). Professional training and the universities: An address given at the opening of the 47th conference of the NZRNA. *The New Zealand Nursing Journal*, June, 10.

degree.³⁴⁵ This signaled the beginning of nearly two decades of sustained activity by the New Zealand Nurses' Association and the Department of Health's Division of Nursing to achieve a place for nursing education within the mainstream of tertiary education.

Conclusion

During the last decades of the nineteenth century, New Zealand nursing achieved public support for the trained nurse, establishing its professional project. With a system of education and a market being accepted, New Zealand became the first country to enact statutory registration for nurses. Grace Neill, New Zealand nursing's first policy entrepreneur, a striking and strong leader, was key to this early development of state endorsement.

Succeeding Grace Neill as Assistant Inspector of Hospitals, Hester Maclean, developed New Zealand's first nursing periodical, established a national professional nursing organisation and served as its first President. She fought opposition to establish the New Zealand Army Nursing Service in World War I, and served as Assistant Inspector, then Director of the Division of Nursing in the Department of Health from 1906 to 1923.

However, the discourse which linked the trained nurse with virtuous womanhood, limited possibilities for nursing. The role of woman, the threat of nursing to medical/male authority, and the economic benefit of a nursing school to a hospital conspired to reduce nursing's autonomy and scope of practice, and supported the exploitation of nurses-in-training. Nurses were often complicit in this discourse, linking their professional project, by association, to the status of doctors; to hierarchy, obedience, and self-sacrifice.

Nevertheless, the New Zealand nursing professional project made gains, growing its public and state support, and building a foundation of training, association, and

³⁴⁵ Miller, N.(1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses' Association, 86.

leadership. But as a female profession, while significant in overall size and importance, nursing fitted within the expectations of mainstream of society.

However, nursing's social and economic relevance, and its powerful, but largely singular and centralised leadership – gave it a sense of certainty around which its professional project could be furthered. The next chapter discusses New Zealand nursing's national and international networks as they developed over the first seventy years of the twentieth century. In particular, it explores the national alignment of power and influence of the Division of Nursing in the Department of Health, the Nurses and Midwives Board, the New Zealand Trained Nurses' Association, and the Postgraduate School for Nurses.

Chapter 5: The “Advance” of Nursing: Building National and International Networks

Organisation is the power of the day. Without it nothing great is accomplished.³⁴⁶

Introduction

Change was incipient in the post-war 1950s. However, the desire for stability was often stronger, causing many attempts at change to falter. Nevertheless, the successes as well as the failed efforts set the stage for campaigns to come.

A foreshadowing of the development of “comprehensive” nursing may be seen in developments in the fifty years following statutory registration. These included changes to statutory regulation that began to elaborate different foci of practice and diminished the separation of female and male nursing. New Zealand nursing was also responsive to recommendations about nursing education arising from the deliberations of international nursing organisations.

This chapter discusses New Zealand organisations for or about nursing and their international connections, focusing primarily on the period 1901 to the 1950s: specifically, the Department of Health’s Division of Nursing, the Nurses and Midwives Board, the Postgraduate School for Nurses, and the New Zealand Registered Nurses’ Association (previously NZTNA). The relationships and work of these organisations are explored within the context of forces, both internal and external to the profession that favoured the retention of the “traditional” approach to nursing. A patriarchal society, control of nursing by doctors and the nursing hierarchy, and nurse training as a means of staffing the country’s hospitals were the forces constraining nursing’s advance in education, practice and development. At the same time, strong central leadership and national and international networks flourished.

³⁴⁶ Palmer, 1897, cited in Sullivan, E. (1999). Editorial: Partners in time. *Journal of Professional Nursing* 15,(2). 67.

The Department of Health and the Nurses and Midwives Board

Despite the fact that women had achieved voting rights in New Zealand in 1893, “women remained well short of full political or legal equality, and still less economic equality”.³⁴⁷ The place and power of women was apparent in the administration of the Nurses Registration Act within the Department of Health. From the Nurses Registration Act of 1901 until 1925, the Nursing Registrar was specified as the Inspector-General of Hospitals (later titled Director-General of Health). From the 1925 Nurses and Midwives Registration Act, which established the Nurses and Midwives Board, until the 1971 Nurses Act, the Director-General was statutorily specified as the Chair of the Nurses and Midwives Board, or in the case of the absence of the Director-General, *any registered medical practitioner who was an officer of the Department of Health*.³⁴⁸ Explicitly, for seventy years, and at the highest level, nursing was required to answer to the medical practitioner.

Furthermore, throughout this period, the statutory responsibilities for ensuring the quality of nursing training and education, and standards for registration were within the same governmental department struggling with issues of local versus centralised funding and control of hospitals and health services. On the one hand this arrangement could be seen to provide the strongest legal position from which to ensure appropriate standards of nursing training and nursing deployment. On the other hand, this could be viewed as duplicity, in that it preserved a system of training that ensured a cheap supply of nursing labour, and one that echoed a conservative patriarchal view of women’s work.

Both statutory requirements anticipated that nursing would answer to a doctor. Nursing, which was established as an independent profession for women against the protests of many doctors, within forty years became subsumed under medical control.

³⁴⁷ Belich, J. (2001). *Paradise reformed: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press, 46.

³⁴⁸ It was not until 1991, with the appointment of Christopher Lovelace, when for the first time the head of the Department of Health was not a medically-trained person. In Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Health*. Wellington: Victoria University Press, 211.

The Health Act (1920) reorganised and renamed the Department of Public Health, Hospitals and Charitable Institutions as the Department of Health.³⁴⁹ The reorganisation integrated the administration of hospital services, public health services, including school health, dental hygiene, child welfare and Maori services. A Division of Nursing was established as one of the seven divisions of the newly created Department.

Hester Maclean had become Assistant Inspector of Hospitals following Grace Neill's retirement in 1909. With the reorganisation of the Department of Health in 1920 she became its first Director, Division of Nursing, retiring in 1923, although she continued as the editor of *Kai Tiaki* until 1931. Dow notes that the change to Director of the newly created Division of Nursing was claimed to be one more "of title than of function".³⁵⁰ While the Division of Nursing still retained responsibilities for hospital inspection, a separate Division of Hospitals had been established, headed by a medical practitioner. Maclean retained her responsibilities as Assistant Inspector-General of mental hospitals in the separate Department of Mental Health; however shortly after the formation of the Division of Nursing, she relinquished this position due to her workload in the Department of Health, and to a lesser degree in the Department of Defence. Structurally, nursing lost further ground in the wider health arena.

While nursing was considered an essential service, it was also seen as primarily a short-term occupation for young, single women. Hester Maclean had bolstered the view of nurse as helpmate to the physician, as well as the requirement for nurse training to be service-based. Rodgers contrasts Neill and Maclean:

Neill was a combatant against the established order of the woman's role and laid the foundations for nurse autonomy and self-regulation through registration. Maclean preserved the concept of woman's role as subservient and obedient. Any educational significance within the training scheme was

³⁴⁹ Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Health*. Wellington: Victoria University Press, 9.

³⁵⁰ Dow, 1995, 93.

lost within the dominant concept held by Maclean that nursing was service based.³⁵¹

With Maclean's dominance over twenty years, during a period of "moral evangelism" followed by the Depression, World War II, and serious nursing shortages throughout the 1930s and 40s, it is not surprising that few real gains were made by nursing, or by women.³⁵² As Belich notes, the period 1890-1930s was "an old story in woman's history – three steps forward, two steps back", and was extended to the 1950s by a near latent period for New Zealand feminism.³⁵³

By the 1950s there were six types of nursing registrations: general, general and obstetric, maternity, general and obstetric plus midwife, psychiatric and male. The 1944 Nurses and Midwives Registration Amendment Act brought the training and registration of psychiatric nurses under the control of the Nurses and Midwives Board. Previously psychiatric nursing education and practice had come under the control of the Department of Health's Mental Hospitals Division.³⁵⁴ The 1945 Nurses and Midwives Act and its subsequent Regulations (1947), provided for the recognition, training and registration of male nurses, and for the first time, permitted the Board to determine the course of instruction and training of candidates for registration.³⁵⁵

However, the Nursing Council was not established as a corporate body until 1971. Effectively for the seventy-year period 1901-1971, all work relating to approval of training programmes and standards for registration was carried out in the same department primarily responsible for the funding of health services, including nurse training.

³⁵¹ Rodgers, J. (1985). *Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos*. Thesis, M.A., Massey University, 43.

³⁵² Belich, 2001, 157-188.

³⁵³ Belich, 2001, 188.

³⁵⁴ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 62.

³⁵⁵ French, P. (1998). *A study of the regulation of nursing in New Zealand 1901-1997*. Thesis, M.A. Victoria University of Wellington.

The Postgraduate School for Nurses

As previously discussed, the Postgraduate School for Nurses, later renamed the School for Advanced Nursing Studies (SANS) operated from 1928 through 1978. It was established with a tripartite management arrangement among the Department of Health, Victoria University and the Wellington Hospital Board following the demise of the Otago University five-year Diploma in Nursing programme.³⁵⁶ However, control essentially resided in the Department of Health. Nursing instructors at SANS were paid by the Department of Health and had responsibilities to both the School and the Department of Health. Often their role in the Department was as inspectors of hospitals.³⁵⁷

Alice Reid Fieldhouse was a student at the Postgraduate School in 1941, and an instructor there from 1948-55, and 1968-72. She, too, was a hospital inspector while also serving as an instructor. Nursing instructors often had to divide their time between the School and the Department. Alice Fieldhouse commented that there were occasions when “they would be called away (from teaching) suddenly because the Minister of Health needed something done.”³⁵⁸

While the management committee of the School reflected the tripartite arrangement, the Department could censor curriculum materials, and instructors found that examination questions might be required to be changed because of ideological differences between the School and the Department.³⁵⁹ For an examination question she developed, Alice Fieldhouse drew on a quote from a journal article that claimed that the practice of nursing was fractionated and similar to an assembly-line process. Word came back from the Department that this particular question was to be cancelled. Elsie Boyd, who was a SANS student in 1952, an instructor there in 1964-65, and from 1965 to 1980 was Assistant Director, Nursing Education in the Division of Nursing, also noted the difficulties of SANS “trying to be an educational

³⁵⁶ N.A. SANS 7/12

³⁵⁷ Hughes, 1978, 32.

³⁵⁸ Interview with A. Fieldhouse, 8 June 2000.

³⁵⁹ Interview with A. Fieldhouse, 8 June 2000.

institution...trying to be independent, which was incredibly difficult for it because it was part of the Department”.³⁶⁰

On the other hand, the relationship and responsibilities between the School and the Department enabled a broad range of nursing expertise to be concentrated, ensured an awareness of regional and national issues relating to pre- and post-registration nursing education, practice, and professional development, and facilitated the maintenance of a strong network for nursing leadership.

During its fifty years of operation, SANS assisted nurses to develop understandings of psychology, sociology, educational theory and practice, nursing service administration and management, public health theory and practice, and nursing education theory, practice and administration—elements all lacking in their hospital-based nurse training.

Perhaps more importantly, SANS challenged students to think. Alice Fieldhouse noted that students “weren’t accustomed to being asked to think and to have opinions, and ...to discuss their differences with other people”.³⁶¹ Janice Wenn, a SANS student in 1969, described its value for her as a juxtaposition of critical intellectual thinking with practicality.

People really listened to your ideas, and if they were crackpot, they’d listen to you and then sort of say, “Well now, let’s go back and work that through”....It started me on a pathway that took me from a sort of intellectual phase, back to putting these things into practical action.³⁶²

SANS students were selected for their academic achievement and perceived leadership potential.³⁶³ For the most part, Matrons “shoulder-tapped” prospective

³⁶⁰ Interview with E. Boyd, 30 August 2000.

³⁶¹ Interview with A. Fieldhouse, 8 June 2000.

³⁶² Interview with J. Wenn, 19 April 2000.

³⁶³ Rodgers, 1985, 85-86.

students, and the hospital board provided a study bursary, although in later years there were some private-paying students. SANS graduates offered examples of “shoulder-tapping” and the interplay between SANS and the work of the Division of Nursing. Nan Kinross explained,

I was there in 1956. In those days we were sent....Nursing Education, which was the major I took, was in fact the complete reorganisation of the nursing curriculum, from whoa to go.... because it had been ordained by the Director, Division of Nursing and the Nurses and Midwives BoardNow one of the most interesting aspects was that we were first introduced to new concepts about nursing and nursing practice from ICN (International Council of Nurses). But also, WHO (World Health Organisation) had produced a series of pamphlets on change in nursing (education). And those new concepts related to a Systems Approach. That had occurred during the late 1940s in the U.S., but it spread to New Zealand in that period.....and the Nursing Education Section (of the Division of Nursing) threw themselves heart and soul into this particular project....we devised a completely new curriculum....It was person-centred and it was ...a systems approach. And that curriculum we devised – that was the whole of our study for that year - devising the curriculum for the whole of New Zealand.³⁶⁴

Margaret Bazley discussed her experiences at SANS as follows.

Yes (I was a student at SANS in 1965). There were one or two independent students, but you tended to be shoulder-tapped. And I did that in subsequent years when I was Matron of Sunnyside..... I started off doing the stream in administration because I went as the Assistant Matron from Seacliff.....And when I'd been there a few months, Miss Orbell, who was the Principal called me in....they were changing me into education because they needed someone to help write psychiatric nursing concepts into the basic curriculum....They wanted me to teach it....So I changed into the education stream and then went off and did the fieldwork....When I came back, I was called in to be told that

³⁶⁴ Interview with N. Kinross, 19 April 2000.

Dr. Mirams (Director of Mental Health), wanted me to go as Matron of Sunnyside Hospital at Christchurch. And so I switched back again. I don't know what I got my diploma in really!³⁶⁵

Elsie Boyd, commented on her nursing education and early experiences:

When I look back and think why did I become so intensely interested in the education of nurses, I suppose it was because I was a product of a very strange system. Even ...when I was a student nurse, I thought, you know, this is all back to front. I'm doing things, and then about six weeks later I'm going off to a study day to find out how to do them.... (Later) I was a theatre sister; the next day I was...plucked up and said well you can teach preliminary school students....So I did that for a couple of years. Then I was plucked out and sent off to do my postgraduate diploma—what became SANS. And here I thought this was just ridiculous—I'm doing something for two years and now I'm going off to find out how to do it....Then I ended up eventually teaching at the Postgraduate School....and all these things got me thinking we're going about this all the wrong way. We're training people to do certain skills at the basic level and then we're trying to fix it up by topping it up at the top.³⁶⁶

Alice Fieldhouse's experience as a student at the Postgraduate School/SANS was typical of many who would become the senior nurses. She was completing her diploma at the Postgraduate School in 1941 when "the senior tutor at Auckland hospital came to see me, and suggested I went and did Plunket training because she wanted somebody to teach the pediatric nursing."³⁶⁷

Additionally, while academically able students were selected, their overall educational backgrounds were often quite different. Alice Fieldhouse spoke about her experiences as a SANS student and teacher:

³⁶⁵ Interview with Dame Margaret Bazley, 18 April 2000.

³⁶⁶ Interview with E. Boyd, 30 August 2000.

³⁶⁷ Interview with A. Fieldhouse, 8 June 2000.

And in times of staffing problems the nursing service was obliged to take on people with perhaps just primary education or not much beyond that. And so that created a problem, and even at the Postgraduate School...people were coming in with a rather poor education background.³⁶⁸

In a 1970 paper prepared for the Director General at the request of Shirley Bohm, Director, Division of Nursing, Beatrice Salmon, then Principal of SANS, cites the 1969 diploma class as representative. She notes that eight of the 46 (17%) “Were very successful ...and utilise concepts from the behavioural sciences in such a way that the nature of their nursing practice is transformed”. Of the remaining students, more than half found the work very demanding and were unlikely to seek further university-level education; and ten out of 46 “did not achieve an acceptable standard of work, and...are unable to consider nursing other than in terms of its technical and traditional functions, and so miss the relevance of their studies...”³⁶⁹ As Elsie Boyd explained, SANS was a “top-up” to an upside-down system.

For forty-five years, until the establishment of nursing studies at the Victoria and Massey universities, SANS was the only source of formal, tertiary-level, post-registration nursing education in New Zealand. Many of its teachers such as Alice Fieldhouse and Beatrice Salmon were considered inspirational and visionary. Some students formed long-standing collegial relationships and professional networks among classmates, instructors, and staff from the Division of Nursing. Janice Wenn recollected:

We were able to explore and share and...afterwards to do some fairly innovative and exciting things together....We really had very special role models....and they were complemented by people from Teachers’ College andVictoria....And then people like Nan Kinross and Gloria Gratton who were at the Department....Those were the role models....particularly Bea....they were really inspiring. And Alice Fieldhouse was born far too early.³⁷⁰

³⁶⁸ Interview with A. Fieldhouse, 8 June 2000.

³⁶⁹ N.A. 1/23/2 Pt 1 (40390), bx 48 SANS Advis Comm. 1968-73).

³⁷⁰ Interview with J. Wenn 19 April 2000.

Nan Kinross commented:

When I think back to the old New Zealand Post-graduate School, it had a vital role in...enthusing all the nurses that came each year....And it wasn't so much what they learned theoretically, it was the skills they developed, and the camaraderie and the friendships they made. And so consequently you had the development of a really critical group...very powerful.³⁷¹

Over that fifty-year period, of the approximately 60,000 nurses on the register, only in the vicinity of 1750 New Zealand nurses had been able to attend SANS.³⁷² However, in spite of the small numbers of nurses who attended, SANS nevertheless added to the profession's capacity to advance an agenda. In addition to their introduction to new ways of thinking about nursing and the world, a close network of colleagues was created for many SANS graduates through their shared SANS dialogue and experience.

New Zealand nursing's first national professional organisation

The formation of a professional association adds to an occupational group's claims to professionalism; and to its influence and power.³⁷³ The establishment of such an organisation is often cited as an early step in the professionalisation of an occupational group. However, as this thesis will demonstrate, the divisiveness of the professional project is revealed from time to time, in the actions of individuals or groups within the organisation.

The Wellington Private Nurses' Association was formed in 1905. Most registered nurses were employed as private nurses in homes or private nursing homes at that time. The Wellington Association, then the Dunedin (1907), Auckland and Christchurch (1908) associations grew out of nursing bureaux established to assist in

³⁷¹ Interview with N. Kinross, 19 April 2000.

³⁷² AJHR, 1973 and 1977 H 31.

³⁷³ Larson, 1977, 76-77.

employment for registered nurses.³⁷⁴ In 1909, at the suggestion of Hester Maclean, then Assistant Inspector of Hospitals, representatives of these four associations met in Wellington to establish the New Zealand Trained Nurses Association.³⁷⁵

Upon its establishment, the Association's objectives were:

1. To bring into accord the Associations of Trained Nurses in the four centres of New Zealand and to promote fellowship throughout the profession of nursing in the Dominion.
2. To further the interests of trained nurses and encourage a high ideal of their profession.
3. By discussion of debatable points in regard to present and future conditions of nursing, to assist in maintaining a high standard of training throughout the Dominion.
4. To discuss, and arrive at mutual agreement with regard to any proposed legislation concerning nurses, and submit such agreement to the Government.
5. In view of the possible recognition of nurses in Great Britain, to guard against the possibility of nurses trained and registered in New Zealand not being eligible for registration on equal terms with the nurses of Great Britain.³⁷⁶

Hester Maclean, who had founded *Kai Tiaki* in the previous year, became the NZTNA's first president (1909-1912). Perhaps it is not surprising that the Assistant Inspector of Hospitals/Director, Division of Nursing was also the president of a professional nursing organisation, given the small number of registered nurses in New Zealand in the first decade following statutory registration. A more contemporary view would see an unacceptable conflict of interest in the Director of the Division of Nursing also having a high profile within a professional organisation for nurses.

³⁷⁴ Smith, M.G. & Shadbolt, Y.T. (Ed.)(1984). *Objects and outcomes: New Zealand Nurses' Association 1909-1983*. Wellington: New Zealand Nurses' Association, 1.

³⁷⁵ Established as the New Zealand Trained Nurses' Association, it became known as the New Zealand Registered Nurses' Association (NZRNA) in 1932, in 1971 the New Zealand Nurses' Association (NZNA), and then the New Zealand Nurses' Organisation (NZNO) in 1993.

³⁷⁶ Smith & Shadbolt, 1984, 2. Note the central importance for New Zealand nurses to have parity and free movement between New Zealand and Great Britain. Recall that Britain did not achieve statutory registration of nurses until 1919.

However, as a developing profession, it was inevitable that nurse leaders acted across educational, clinical, and professional organisational spheres of influence. The movement and roles of nurses within the Department of Health (including SANS and the Nurses and Midwives Board), and the professional organisation is particularly notable. Jessie Bicknell, Hester Maclean's successor in the Department, became President of the NZRNA in 1935 following her tenure in the Division of Nursing. Mary Lambie, one of the two inaugural instructors of the Postgraduate School, subsequently became Director, Division of Nursing (1931-50). Dame Margaret Bazley, SANS graduate (1964), Matron of Sunnyside Hospital (1965-73), served as a member of the Nurses and Midwives Board from 1966-72, was President of the NZNA during 1972-74, and was the Director, Division of Nursing from 1978 until 1984, when she was the first woman to be appointed as State Services Commissioner.³⁷⁷

Dr. Nan Kinross, who held positions on the NZNA executive and served on national NZNA committees, was also an Assistant Director in the Division of Nursing (1967-73). She notes "in the early years, the Association and the nurses of the Department of Health were one and the same".³⁷⁸ Writing in 1984, Miller commented on the significance of the "close relationship the Association has always had with the Department of Health".³⁷⁹

Early business of the Association focused on membership matters, and concerns about training being permitted in very small hospitals. Masseuses were granted auxiliary membership, but trainee nurses' membership was denied, and physicians were later permitted honorary membership only.³⁸⁰

³⁷⁷ McLoughlin, D. (2001, 29 September). A passionate woman. *The Dominion*, 2.

³⁷⁸ Kinross, 1984 b, 95.

³⁷⁹ Miller, N.(1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses' Association, 79.

³⁸⁰ Smith & Shadbolt, 1984, 2-3.

Association activities were curtailed by World War I, but by the 1920s members were involved on many fronts, particularly education and legislation related to establishment of a Nurses and Midwives Board. The efforts of the NZTNA toward the establishment of a nursing education programme with both pre-and post-registration components as part of the University of Otago have been well documented by Hughes, and previously discussed. The Association saw the importance of insuring that nurses and midwives constituted the majority of membership of the proposed Nurses and Midwives Board. Nurses achieved the majority voice, as the 1925 Act provided the following membership:

Director-General, Chairman

Director, Division of Nursing, Registrar

A member of the medical profession nominated by the Minister of Health

Two nurses, one of whom must be a midwife, nominated by the NZRNA.³⁸¹

The Nurses and Midwives Act 1925 specified the Director, Division of Nursing as the Registrar. However, while a board was specified for the first time, its Chairman and Registrar were employer and employee, and had respective primary responsibilities to provide for a national health system and the nursing services of that system. Essentially, there was no change in the power-policy structure.

Kinross notes “the bipartite approach (Association and Department) to nursing had become a triumvirate with considerate power vested in the nurse who was both Director, Division of Nursing and Registrar of the Board”.³⁸² However, it would seem this power was shaped and diffused by stronger forces of tradition, conservatism, and patriarchy. For nearly another fifty years, nursing training continued to be the expedient means of ensuring patient care. Not only was apprentice-style training was retained, but programmes were permitted to be established in small hospitals, and further types of registration categories and programmes were established to meet niche staffing shortages.

³⁸¹ Kinross, 1984 b, 110.

³⁸² Kinross, 1984 b, 110.

International connections

New Zealand nursing's strong international connections relate back to the Nightingale disciples, and to Grace Neill's participation in the 1899 International Council of Women Congress and subsequent involvement in the establishment of the International Council of Nurses (ICN) that same year. New Zealand nursing was able to grow sustaining international links from these seeds.

“From the outset, *Kai Tiaki* was a powerful influence in developing and expanding the international idea within New Zealand.”³⁸³ Its founder, Hester Maclean received publications from the American, British, Dutch and French nursing associations. From these she extracted news of nursing developments in other countries to publish in *Kai Tiaki*.

Following the establishment of the NZRNA in 1909, New Zealand was able to join the ICN, becoming its ninth member country. New Zealand nurses had attended ICN congresses since its inception, and often became members of important ICN committees. Salmon notes,

New Zealand nurses, with their thirst for travel, coupled with a genuine desire to be part of the international community of nurses and nursing, continued to attend in surprisingly large numbers. This must have been no mean feat of personal organisation considering the low salaries paid to nurses at the time, the long and sometimes arduous weeks of travel, and absences from employment.³⁸⁴

Scholarships for study abroad were another thread of international connections. In 1923 the Department of Health had funded Janet Moore and Mary Lambie to study at Bedford College, London and the University of Toronto, respectively, in preparation for their roles at the planned University of Otago nursing programme. New Zealand's

³⁸³ Salmon, E. B. (1984). The international idea. In M.G. Smith & Y.T. Shadbolt (ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp120-138). Wellington: New Zealand Nurses' Association, 121.

³⁸⁴ Salmon, 1984, 123.

Florence Nightingale Committee awarded its first scholarship in 1935 to Elizabeth Bridges, then a member of the Department's Division of Nursing, to study at Bedford College. Upon her return she was appointed to the Postgraduate School for Nurses, joining Miss Moore and Miss Lambie.³⁸⁵

Ngaire Miller details other nurses who were assisted by the Florence Nightingale fund, including overseas nurses supported to study in New Zealand following World War II.³⁸⁶ In the 1950s the first New Zealand scholarship of the British Commonwealth Nurses' War Memorial Fund became available. Elsie Boyd, then a tutor at the Auckland Hospital School of Nursing, later an instructor at the Postgraduate School for Nurses, and subsequently Assistant Director, Nursing Education in the Division of Nursing was among the early recipients. Boyd later received a World Health Organisation (WHO) Travelling Fellowship. Other recipients included Nan Kinross, for completion of a Master of Science (Nursing) at the University of California in Berkley, and Beatrice Salmon to complete a Bachelor of Science (Nursing) at McGill University in Toronto.

The international community of nursing was to have steady influence on New Zealand nursing through reports of international developments in *Kai Tiaki*, the influence of academic study and experiences abroad on New Zealand nurses, and their involvement in international organisations such as the ICN and the World Health Organisation.

Nursing research: Seeking a professional footing

In spite of Florence Nightingale's powerful use of research in the Crimean War, restricted curricula, rigid rules, and long hours of work in hospital training stunted the development of critical thinking, and other skills for research. Nursing research was nurtured and utilized by a few nursing leaders in the United States in the first half of the 20th century, and by the 1950s was achieving a firm foundation in North

³⁸⁵ Salmon, 1984, 124.

³⁸⁶ Miller, 1984, 83-85.

America.³⁸⁷ By this time, nursing leaders in New Zealand were developing an increasing awareness of the need for nursing research skills.

The ICN, through the Florence Nightingale International Fund, organized the first international nursing research conference in Sevres, France in 1956. Shirley Lowe (Bohm) was an NZRNA representative to the conference, and noted its significance both personally and for NZNA.³⁸⁸ A few years later, in 1960, Mrs. Bohm was appointed as a Nurse Advisor in the Department of Health, and in 1962 was “seconded to work with Dr John Jeffery to obtain finance from the Government to set up a research unit” in the Department.³⁸⁹

In 1960, a second international nursing research conference, *Learning to investigate nursing problems*, was held in New Delhi. Among the representatives of sixteen countries, thirty-four New Zealand nurses attended, including an instructor from the Postgraduate School for Nurses and assistant editor of *Kai Tiaki*.³⁹⁰ The participation of New Zealand nurses in these conferences, and the published reports from both the 1957 Conference and the 1960 Seminar were seen as having given “nurses in this country a start in nursing research...”³⁹¹ Indeed, the 1964 *Plan for Nursing in New Zealand*, prepared by the Curriculum Committee of the Nurses and Midwives Board, noted that postgraduate education for “leaders of the profession...clinical experts, teachers, administrators, consultants and research workers” would be best met by the Postgraduate School for Nurses in association with a university Nursing

³⁸⁷ Gortner, S. (1999). Knowledge development in nursing: Our historical roots and future opportunities. *Nursing Outlook*, 48(2), 61.
Donahue, M.P. (1985). *Nursing the finest art: An illustrated history*. St Louis: C.V. Mosby, 450-452.

³⁸⁸ Interview with S. Bohm, 25 March 2000.
Salmon, E. B. (1984). The international idea. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp120-138). Wellington: New Zealand Nurses' Association, 128.

³⁸⁹ Interview with S. Bohm, 25 March 2000.

³⁹⁰ Salmon, 1984, 128, 131.

³⁹¹ Salmon, 1984, 131.

Department.³⁹² This appears to be one of the first references to the role of nurses in research in official documents in New Zealand.

Janice Wenn, a SANS student in 1969, and then an instructor there from 1972-76, commented that during that period “there were people who were starting to think about research, and what it was that we needed”.³⁹³ By 1974, ten years after the *Plan*, forty years after the failed University of Otago programme, and seventy years since Dr. Pabst urged the University of New Zealand to confer a degree in nursing, there were only two senior nursing lecturer appointments, one at Massey University and one at Victoria University. There was no undergraduate programme leading to registration, and no masters level programme. After “seventy years of hopes, disappointments and perseverance”³⁹⁴ New Zealand nursing research was yet to develop.

Conclusion

This chapter has explored the importance of the New Zealand Trained Nurses’ Association, the Postgraduate School for Nurses/SANS, and the Division of Nursing, including the Nurses and Midwives Board, in the Department of Health. In particular, SANS was an incubator of many nursing leaders, a crucible for ideas and innovations, and a generator for enduring and effective nursing networks. These leaders and their networks were concentrated in SANS, the Association, the Division of Nursing and the Nurses and Midwives Board. Nevertheless, SANS was a compromise which ensured that all of nursing education remained within the control of the Department of Health.

New Zealand nursing’s historic connections with the International Council of Nurses, its colonial mother-country and cousins, and later the World Health Organisation

³⁹² N.A. H1 22734 SANS, Nurses File-Dept of Health. A plan for nursing in New Zealand, October, 1964, 2-3.

³⁹³ Interview with J. Wenn, 19 April 2000.

³⁹⁴ Salmon, B. (1981). New Zealand universities and nursing education: The first seven decades. In P.Carroll, A. Fieldhouse, S. Shaw (Ed), *A profession in transition.*(pp 60-64) Wellington: C.L. Bailey Nursing Education Trust, 62.

provided rich networks and important connections. Writing in 1984, Beatrice Salmon noted

One of the unique features of New Zealand nurses' participation in international nursing...has been the fact that frequently one particular influential person was involved in a variety of activities on a wide front. That person was usually the Director Division of Nursing..., who also took a leading role in the Association. This was due to our historical development, our extreme geographical isolation, the expense of travel, limited numbers of well-prepared nurses in a small population, and our tradition of strong central government control. This rather unusual situation persisted until the middle 1960s.³⁹⁵

During this time, some individual nurses demonstrated astute political awareness, developed instinctively, or through their experiences in the NZTNA or the Department of Health. Collective action and the development of nursing research were to come later.

Writing about similar nursing development in America, Fitzpatrick comments on the history of its organisations:

No other single force has shaped the course of events more or contributed as much to the attainment of professionalism. Organizations have served as mechanisms for effecting progressive changes in nursing practice, education....They have provided channels of communication...have been the forum for exchange of ideas and collectives for action...Nursing organizations have encouraged and fostered the development of nursing research and have assisted in securing a distinct and significant identity for nursing within the health care arena.³⁹⁶

³⁹⁵ Salmon, 1984, 137.

³⁹⁶ Fitzpatrick, M.L. (1983). *Prologue to professionalism*. Bowie: Robert J. Brady Co, 143.

While this reflection ignores the periodic capture of organisations by a conservative, traditional mindset, or the ability of one or more powerfully placed individuals to resist change, it does underscore the critical significance of organisations for the professional project. The following chapter explores the circumstances, forces and voices that led to New Zealand nursing's most concerted and sustained political action.

Chapter 6: From apprenticeship to diploma and degree - Advancing the profession

“The first point I would make is that nursing service can only be effectively provided by a qualified practitioner.”³⁹⁷

Shirley Bohm, 1970

Introduction

The transfer of nursing education from hospital-based apprenticeship to tertiary education was a move which American nurse leaders, reflecting on their own similar experience, saw as,

bold...controversial, disrupted the status quo, and required nursing leaders to move beyond their own backgrounds, experience and work settings to pioneer a new educational approach for future nurses....That action has probably been the single most influential factor in advancing the profession during the twentieth century.³⁹⁸

This chapter explores the protracted, but ultimately successful efforts to improve a system of nursing education tied to hospital labour force requirements; to establish a post-registration degree programme in nursing, and to fully achieve a comprehensive approach to nursing theory and practice within the tertiary education system. This long campaign is contrasted with the almost serendipitous and relatively rapid change from diploma to first degree as requirement for entry to the register.

A re-awakening

By the late 1950s and throughout the 1960s, multiple warning flags signaled the need for major changes in nursing education and nursing services. Persistent shortages of nurses, deficiencies in the standard of nursing service, a renewed emphasis on public

³⁹⁷ ATL, NZNA correspondence with the Director, Division of Nursing 30/3/3. Report given by Shirley Bohm to the Meeting of Divisional Directors and Assistant Directors, Head Office, Department of Health, Wellington, 4 May 1970.

³⁹⁸ American Association of Colleges of Nursing. (1998). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC: Author, 20.

health, and a growing awareness that New Zealand nursing education and research were falling behind other countries were red flags. The New Zealand Registered Nurses' Association, the Division of Nursing, and the Nurses and Midwives Board gradually mounted a campaign, rekindling the goal initiated in 1923, that university nursing education be available in New Zealand for at least some nurses. This culminated in the demand for all nursing education to be located in mainstream tertiary education.

While the gathering evidence of the 1950s and '60s was part of the post-war shift in social and economic order, it was to some extent unseen by government bureaucracy and society as a whole. Deborah Montgomerie and James Belich both describe the restoration of "gender order"³⁹⁹ and the need for continuity over change,⁴⁰⁰ which marked the post-war period. Thus, throughout these two decades, solutions to problems were seen primarily through the lens of the status quo, and challenges to the established order were generally met with minor adjustments.

Shortage of nurses

In his speech to open the 1950 conference of the New Zealand Registered Nurses' Association, the Minister of Health, T.J. Watts explored the problem of the shortage of nurses resulting in closure of hospital wards.⁴⁰¹ He noted that the growth in the Social Security system and an expansion of technical medical knowledge contributed to the doubling of hospital beds in the previous twenty five years; and that while the "introduction of better methods of training of nurses, e.g. the block system and study day classes, whereby nurses [sic] can attend classes when free from ward duties...this necessitates an increase in the total number of nurses".⁴⁰²

³⁹⁹ Montgomerie, D. (2001). *The women's war: New Zealand women 1939-45*. Auckland: Auckland University Press, 11

⁴⁰⁰ Belich, J. (2001). *Paradise reformed: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press, 321.

⁴⁰¹ Watts, T. J. (1950). Conference opening address. *The New Zealand Journal of Nursing*, May, 68-70.

⁴⁰² Watts, 1950, 69. : Mr Watts' view of who was a nurse was typical of the times.

Further exploring the persistent nursing shortage, Watts commented on the “itchy feet” of nurses wanting to travel overseas, and the societal expectation that married women would not be in paid employment. “No sooner have we trained a girl to be of real use in the hospital service of New Zealand than she goes away and gets married.”⁴⁰³ This understanding of the nurse as a student-in-training, as a “girl”, and as someone to become of “use” exposes the utilitarianism of the health service.

Watts went on to suggest that the shortage of nurses would be remedied by the anticipated coming of age in 1954/5 of young women born during baby boom years of 1936/7. And as a further stopgap, bringing nurses from overseas, along with “more economic use of our nursing staff, better planning of works in hospitals, better provision of domestic and part-time staff, bright, cheerful furniture and better amenities and facilities in the nurses’ homes”⁴⁰⁴ would help address the underlying problems. Lastly, as is inevitably brought to bear on a nursing shortage, Watts announced a wage increase for nurses of between 5-7 percent, and in closing, offered his belief that,

nursing offers to our young women work which is a service, work which has a long tradition behind it, work which calls for and brings out the very best in women and must endow those who undertake it with a lasting and deep satisfaction.⁴⁰⁵

Watts’ comments suggested that nurse training got in the way of ensuring sufficient hands to do woman’s work, and indicate annoyance that the aspirations and expectations of nurses (women) were not compatible with the organisation of the health service. Rather than appreciating and addressing the root causes of the shortage, Watts proposed a cosmetic solution - while pay would be improved, a more attractive nurses’ home and the opportunity to do good work, should suffice.

⁴⁰³ Watts, 1950, 69.

⁴⁰⁴ Watts, 1950, 69.

⁴⁰⁵ Watts, 1950, 70.

The reality was an expanding health service that required more and better educated nurses. There was both a rising birth rate and an aging population stretching nursing services. Developments in medical knowledge and technologies during the war had led to new treatments and surgeries increasing hospitalisation rates and the need for nursing in the post-war period. Additionally, nursing was increasingly involved in health promotion, health education, and occupational and public health. New Zealand nurses were also serving in United Nations post-war refugee relief and helping to (re)build nursing education and service in many countries. At the same time, the intake of nurses-in-training was lower than required for the same patterns of a public hospital nursing service based on students. Nurses were also leaving their training. In the post-war return to domesticity, twenty-seven percent of nurses who left training gave marriage as the reason.⁴⁰⁶ Long hours, one day off a week, rigid hierarchical work coupled with the requirement to “live in” at the nurses’ home, and risks to personal health were among the features which had to be addressed if the nursing shortage was to be overcome. Eventually these issues began to be addressed, but in the 1950s, the answer was largely to down-play them by appealing to nursing’s traditional altruistic motives.

Nursing itself contributed to the rhetoric of dedication, selfless service and devotion into the post-war period and beyond. In response to dialogue about the Association registering as a union, Cecelia McKinney, President of NZRNA, addressing the 1941 annual conference said, “Nursing is not just a job. Unions, however valuable, with their demands and possible strikes, have no place in nursing. Nursing is very much more giving than getting.”⁴⁰⁷

A few years later, Flora Cameron painted nursing students themselves as a cause of the nursing shortage, and exhorted them not to discuss the realities of their work, lest it deter others from considering nursing training:

⁴⁰⁶ Nolan, M. (2000). *Breadwinning: New Zealand women and the State*. Christchurch: Canterbury University Press, 226.

⁴⁰⁷ Carey, S. (1984). Professionalism and unionism: Transcending the conflict. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses’ Association 1909–1983*. (pp. 22-44). Wellington: New Zealand Nurses’ Association, 34.

All the publicity given to the drudgery the nurse has to go through, is really due to nurses themselves. The way you discuss happenings when you visit away from the hospital, you tell your friends how tired you are, the hours you have worked, the things you have been unjustly blamed for, are all listened to by the younger girls....It lies within the power of all of us to recruit the right type of girl to our profession.... safeguard the example set us by our leaders who have so ably guided and represented us in the past.⁴⁰⁸

Nursing student leaders internalised this ideology, perpetuating a leadership which was by the 1960s increasingly going against the flow of society. But in 1954, the President of the Student Nurses Association again coupled commitment to ideals with self-sacrifice.

But the things that will give us unity and strength...are fundamentals...I am speaking of love – love to our fellow men, loyalty to those with whom and for whom we work, and above all, honour....We hold in our hands the torch of light and we must use it to the very best of our ability and that wherever we may go we will not falter in our privileged task of helping to build a healthier and happier nation.⁴⁰⁹

In the same spirit, June Transom went on to encourage her fellow nursing students to also commit to work with developing countries in the Pacific and Asia, and then she continued,

There is one more thing...and that is the part all of us can play in the recruitment of nurses....Instead of telling people how tired and overworked we are, why don't we tell them about the fascination of our work, of the comradeship we get from our fellow nurses and the life-long friends we make. Be enthusiastic about our work, and even if we do feel tired and overworked, well

⁴⁰⁸ Cameron, F.J. (1951). Student nurses' conference: Address by Miss F.J. Cameron, Director, Division of Nursing, Department of Health. (1951). *New Zealand Nursing Journal*, Vol. XLIV, No. 6, August, 137.

⁴⁰⁹ Transom, J. (1954). Student nurses' conference: Presidential address. *New Zealand Nursing Journal*, XLVII,(4), 130.

then, try to forget all about it and remember only the best and happiest moments.⁴¹⁰

Nevertheless, the NZRNA had begun to address matters of salary and working hours. In 1945 NZRNA Executive had advocated for the establishment of a national Salaries Board to determine nurses' wages, rather than each individual hospital board.⁴¹¹ In 1946 the Minister of Health indicated his intention recommend such a board, and following the confirmation of the Hospital Boards' Employees (Conditions of Employment) Regulations, the NZRNA was recognised as an employee organization. Under these regulations, the Hospital Board Nurses' Salaries Advisory Committee was established. However, the committee met only sporadically from 1947, and nursing's ability to address conditions of employment were stifled until the 1969 State Services Remuneration and Conditions of Employment Act.⁴¹²

Other responses to the nursing shortage continued to reflect the belief that all that was required were more dedicated girls. The age of registration for the general nurse was reduced to twenty (1957 Nurses and Midwives Amendment Act), and two new categories of training and registration were created: the psychopaedic nurse (1960 Nurses and Midwives Amendment Act); and the registered community nurse (1965 Nurses and Midwives Amendment Act).

These measures might have been sufficient in another era. But women's expectations in the 1950s and 1960s were changing. A study conducted in 1967 explored role perceptions and educational and occupational aspirations of nearly 1000 fourteen year old girls in several towns and cities of the lower North Island. Fifty-five percent of the girls expected to engage in further educational training following high school. Furthermore, while most girls expected to marry, they also expected that they would work full-time after marriage, stop work when they had children, and then return to

⁴¹⁰ Transom, 1954, 131.

⁴¹¹ Carey, 1984, 25.

⁴¹² Carey, 1984, 26-27.

work when the children were grown.⁴¹³ At the same time, older girls and young women also reflected this change in expectations. A 1968 study examined the role perceptions of nursing students. It found that while marriage was a priority for the majority of those interviewed, students were also interested in pursuing their careers after marriage, working either part-time or full-time.⁴¹⁴

These changes had been developing over several decades. Nolan describes how conservative but outspoken feminists, alongside left-wing, radical women's organisations contributed to a social and political discourse regarding women's rights in the 1930s - "between the two classic waves of feminism"⁴¹⁵ of the 1890s and 1960s. While within each of these groups there was a great deal of difference around women's employment issues, they were united in their support for better economic citizenship for employed single women without dependents. For young women, paid employment had moved from being the exceptional experience in the 1890s, to over half of all women between 15 and 24 working in the 1920s, to being the majority experience by 1940.⁴¹⁶ Married women's participation in the workforce doubled from 3.7 to 7.7 percent between 1936 and 1945, and had doubled again to 16 percent by 1961.⁴¹⁷ By 1971 married women comprised 26 percent of the workforce; and half of the female workforce.⁴¹⁸

With more employment options open to women, the nursing shortage persisted. Gradually, nurse leaders came to see that something must be done - but what? The model of staffing hospitals through provision of training had persisted for over seventy years. It was difficult to envision a wholly different approach. Overseas

⁴¹³ Croy, B. (1968). Correlates of educational and occupational aspirations of adolescent girls. In partial fulfilment of the requirements for the degree of Master of Arts, University of Canterbury.

⁴¹⁴ Penny, M. W. (1968). The student nurse in New Zealand: An exploration in role perception. M.A. thesis. Master of Arts in Sociology, University of Canterbury.

⁴¹⁵ Nolan, M. (1993). 'Politics swept under a domestic carpet?' Fracturing domesticity and the male bread-winner's wage: Womens' economic citizenship, 1920s-1940s. *New Zealand Journal of History* 27(2), 206.

⁴¹⁶ Nolan, 1993, 215.

⁴¹⁷ Belich, 2001, 502.

⁴¹⁸ Belich, 2001, 502.

models were not necessarily seen to be appropriate or workable in the New Zealand socio-economic and cultural milieu. Even when the socio-political environment had begun to change, nursing leadership itself was caught in whirlpools and eddies of uncertainties and differences of opinion.

Post-war changes: International voices, national responses

The expansion of science and technology during and after World War II had brought significant advances to health care. Accruing from this, nursing care became

increasingly more complex...To effectively give care, nurses needed to be able to identify very subtle changes in patients' status, learn new sophisticated treatment techniques, increase their ability to interpret laboratory data, recognize delicate physiological interrelationships, and closely monitor the efficacy of potent and sometimes experimental forms of drug therapy.⁴¹⁹

In her report of her visits in 1947 to North America and Scandinavia, Mary Lambie noted that "throughout the Anglo-Saxon and Scandinavian countries there has been a marked increase in hospitalisation over the last six years. Canada estimates this at 46% increase and in the USA I heard it quoted even at 50%".⁴²⁰ Lambie's report also brought attention to the new pattern of early ambulation of surgical patients, increasing acuity of patients, as well as an increase in more chronically ill patients. The dependence of the medical science on nursing to actualise the benefits of new approaches to patient care not only made the "actual nursing load heavier,"⁴²¹ it required a new approach to nursing education and practice.⁴²²

⁴¹⁹ Fitzpatrick cited in Donahue, M.P. (1985). *Nursing the finest art: An illustrated history*. St Louis: C.V. Mosby, 447.

⁴²⁰ NA H, I 22927(21/40) Report to the Director-General of Health, 1947, Mary Lambie.

⁴²¹ NA H, I 22927(21/40) Report to the Director-General of Health, 1947, Mary Lambie.

⁴²² Burgess, 1984, 21-22.
Carroll, M.P. (1984). Basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983*, (pp 64-78). Wellington: New Zealand Nurses' Association, 73.
Donahue, 1985, 447.

Concerns for the nature of the training and the curriculum were being expressed by nursing leaders in a range of fora from the early to mid-1950s. Flora Cameron, appointed Director, Division of Nursing in 1950, urged the adoption of a curriculum that would provide for a “better integration of the health and social aspects of disease”,⁴²³ for the inclusion of obstetric and psychiatric nursing within the “general” training, and for an end to routine, regimentation and repetition in training.⁴²⁴ Flora Cameron drew attention to the consequences of the long-accepted method of staffing hospitals primarily with nurses-in-training. She underscored the impossibility of providing a pedagogically sound training programme in a situation where the profession itself was limited in its scope to determine its educational standards.

Following World War II, the International Council of Nurses (ICN) and the World Health Organisation (WHO) considered countries’ needs for nursing, and produced a number of publications on the conclusions of their debate and dialogue. As discussed in the previous chapter, New Zealand nursing’s connections with the ICN and WHO were highly valued.

The WHO Expert Committee on Nursing produced a series of reports that were discussed in *Kai Tiaki*, and carefully considered among nurse leaders in New Zealand. Over the period 1950s and 1960s, these reports influenced a range of incremental changes to the scope of nursing education in New Zealand, increasingly pointing to the need for “comprehensive” nursing education, and opportunities for degree study in nursing.

However, fifteen years later, the situation appeared no better. With staffing still a concern, payment for overtime and compensation for shift work were introduced, and the hope was expressed that “by 1970 nursing service in hospitals should...be advanced to the stage that every ward has registered nurse coverage for 24 hours of the day”.⁴²⁵

⁴²³ Cameron, F. (1954). Trends in nursing overseas. *The New Zealand Nursing Journal*, Aug., 132.

⁴²⁴ Cameron, F. (1955). Training - or education. *The New Zealand Nursing Journal*, Oct., 155-157.
Cameron, F. (1956). Address by Miss F. J. Cameron, OBE on the new curriculum: 1956 Conference of Training School Matrons. *The New Zealand Nursing Journal*, June, 111-115.

⁴²⁵ AJHR, 1965, H-31,52.

Addressing the Conference of Training School Matrons in 1956, Flora Cameron explained and urged the endorsement of proposed curriculum changes based on the *WHO Expert Committee on Nursing Third Report*, other international literature, and her overseas experience.⁴²⁶ Obstetric nursing was to be incorporated into general nursing training, along with more conceptual curricular changes, such as understandings of health, a family and community approach, and linking theory and practice. She also suggested that students might be permitted to live in their own homes for at least part of their training. Her closing remarks are telling:

Our nursing training at the present time is outdated. Many overseas countries are already doing all that the new curriculum suggests. It is time we conducted ours on more modern lines....The nursing journals of all countries are full of plans for changes in the nursing curriculum. In changing ours we are only putting into practice what many are doing and what most countries will have effected within the next few years. We have so far led in many things. Are we now going to wait till every other country has made changes?....⁴²⁷

While the inclusion of obstetric nursing was seen a “major change”, it was only part of the overall curriculum changes instituted by the Nurses and Midwives Board in 1956.⁴²⁸ Nan Kinross was a student in the nursing education stream at the Postgraduate School for Nurses in 1956. She and her fellow students were charged with developing the new curriculum, to be based largely on the recommendations of the ICN and WHO Expert Committee on Nursing report series. According to Dr. Kinross, it was

⁴²⁶ Cameron, 1956.

⁴²⁷ Cameron, 1956, 115.

⁴²⁸ Pitts, A.M. (1984). Nursing services. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983*, (pp 45-63). Wellington: New Zealand Nurses' Association, 54.
Interview with N. Kinross, 19 April 2000.

...the complete re-organisation of the nursing curriculum, from whoa to go... because it had been ordained by the Director, Division of Nursing (Flora Cameron), and by the Nurses and Midwives Board....So this new curriculum was really quite radical.... A holistic approach.⁴²⁹

The new curriculum also introduced psychology, human growth and development, psychiatric nursing concepts, and public health concepts and practice.⁴³⁰ Jocelyn Keith saw the new curriculum as a harbinger of the end of the hospital schools of nursing, noting that,

The students of Elizabeth Orbell (at the Postgraduate School) laboured to produce...a curriculum which used an age-continuum approach, which began with health rather than disease. They found existing textbooks useless, and hospital school nursing libraries inadequate, or worse, nonexistent. Inevitably, hostility to innovation and change came from all quarters, within and without the profession. But there was no turning back.⁴³¹

In 1964 the General Nursing Council of England and Wales withdrew automatic reciprocity for New Zealand nurses to register there. This occurred because the General Nursing Council had revised the minimal size for a hospital school of nursing to 240 beds, and New Zealand had only 12 out of its 41 schools able to meet the new criteria.⁴³² This action was perhaps not unexpected in the Department of Health, where concerns about the number of small hospitals providing nurse training had been

⁴²⁹ Interview with N. Kinross, 19 April 2000.

⁴³⁰ Interview with N. Kinross, 19 April 2000.
Shadbolt, Y. (1983). Nursing education: A major shift. *The New Zealand Nursing Journal*. January (Jubilee Issue), 9.

⁴³¹ Keith, J.(1989). The impact of American ideas on New Zealand nursing education: Part 1, The view from The Journal. In David Philips, Geoff Lealand & Geraldine McDonald ed. *The impact of American ideas on New Zealand's educational policy, practice and thinking*. (pp. 199-211).Wellington: NZ-US Educational Foundation. New Zealand Council for Educational Research. 209.

⁴³² Carroll, M.P. (1984). Basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983*, (pp 64-78). Wellington: New Zealand Nurses' Association, 74.
Shadbolt, Y. (1983). Nursing education: A major shift. *The New Zealand Nursing Journal*. January (Jubilee Issue), 8.

about since the early 1900s. However, the news came as a shock to New Zealand nurses, and the loss of automatic reciprocity from the “Mother Country” served as one more wake-up call.

As nursing leaders struggled to ensure that the context for nursing education was appropriate for health care needs, redesign of the New Zealand nursing curriculum continued. The Curriculum Committee of the Nurses and Midwives Board in 1964 included well-positioned and well-qualified representatives from nursing training schools, obstetric and psychiatric nursing, the NZRNA, medical associations, and the Department of Health.⁴³³ Audrey Orbell, appointed Director of the Division of Nursing following Flora Cameron’s retirement in 1963, was also the Registrar of the Nurses and Midwives Board, by virtue of her position as Director.

Four other of the eleven members of the committee were part of the Division of Nursing. Shirley Lowe (later Bohm) was Assistant Director. Elizabeth Orbell, also an Assistant Director, was Principal of SANS. Rita McEwan was a Nurse Inspector for the Department of Health, and a SANS instructor. Thelma Burton was also an instructor at SANS, and at the time was the Executive Director of the NZRNA.⁴³⁴

Ena Hollis, President of the NZRNA, represented the Association on this committee. Nan Kinross, one of the two representatives for nurse training schools, was at the time the Supervising Matron of Southland Hospital. Just two years prior she had completed her Master of Science in Nursing at the University of California, Berkeley,

⁴³³ NA H1, 22734 SANS, Nurses file- Dept of Health. *A plan for nursing in New Zealand*, October, 1964, 1. Members of the Nurses and Midwives Curriculum Planning Committee were:
A. Orbell, RN, RM, Dip.N., Registrar Nurses and Midwives Board;
E.N. Hollis, RN, RM, Dip.N. Pres. NZRNA;
E. Orbell, RN, RM. Dip. N, Asst. Director of Nursing, and Principal, Postgraduate School for Nurses;
S. Lowe (Bohm) RN, RM, Dip. N. , Asst. Dir. Nursing, Dept of Health;
N. Kinross, RN, RMN, Dip. N, B.A., M.Sc., Supervising Matron, Southland Hospital;
M. Hosking, RN, RM, Dip. N. Tutor Sister, School of Nursing, Auckland;
T. Burton, RN, RM, Dip N. Nurs Admin (RCN) Instructor, Postgraduate School for Nurses;
R. McEwan, RN, RM, R.Psy.N., Dip. N. Nurse Inspector, Division of Nursing, Dept of Health;
KM White, MA, Formerly Vice Principal, Wellington Teachers’ College;
E.L. Button, M.B. Ch.B, FRCS, Consultant Surgeon, Wellington; and
G.F. Smart, M.B., BS, FRCS, Medical Superintendent, Wairau Hospital.

⁴³⁴ Smith, M.G. & Shadbolt, Y.T. (ed.)(1984). *Objects and outcomes: New Zealand Nurses’ Association 1909-1983*. Wellington: New Zealand Nurses’ Association, 166.

and within three years, she would become Assistant Director for Nursing Education in the Division.

Their plan to effect a more comprehensive approach to nursing included measures to address their concern to support nursing tutors in this change process. Margaret Bazley was a student at SANS in 1965. She was asked to change from the management stream to education in order to develop a six-month course in psychiatric nursing to prepare general nursing tutors for teaching in a more comprehensive basic curriculum.⁴³⁵

The WHO *Fifth Report* (1966) recommended “that the education of the nurse, at basic, as well as post-basic level be incorporated into the system of higher education”.⁴³⁶ It continued to urge a holistic approach to nursing knowledge to inform care, “rather than the almost exclusive biological orientation.”⁴³⁷ In this same period, ICN was evolving a definition of “professional nurse” which further stirred debate and change. As recommended by the education committee of ICN in 1957, the definition ultimately influenced the establishment of comprehensive nursing education in New Zealand. In this definition,

a professional nurse is one who has completed a comprehensive nursing preparation in an approved School of Nursing... Such comprehensive preparation shall include instruction and supervised practice in order to prepare the nurse to care for people of all ages in the promotion of health and in all forms of sickness, both mental and physical.⁴³⁸

Daisy Bridges, General Secretary of the ICN from 1948-1961, noted,

⁴³⁵ Interview with M. Bazley, 18 May 2000. This work led to the first textbook authored by New Zealand nurses, Bazley, Cakman, Kyle, & Thomas. (1973). *The Nurse and the Psychiatric Patient*.

⁴³⁶ World Health Organization. (1966). *WHO Expert Committee on Nursing, 5th Report*. WHO Technical Series No.347. Geneva: Author, 30.

⁴³⁷ Salmon, B. (1968). Have you read the WHO Expert Committee on Nursing, Fifth Report? *New Zealand Nursing Journal*, 11.

⁴³⁸ Bridges, D. (1967). *A history of the International Council of Nurses 1899-1964*. Philadelphia: J.B. Lippincott Co, 213.

the question as to what... should be understood by the term registered professional nurse, and what should be the essential basic preparation for professional status, was to be a major concern to the ICN and its member associations...⁴³⁹

It was certainly a concern for New Zealand. Its approaches to nursing education and nursing service were entrenched. A few years earlier Flora Cameron had suggested that

the time has perhaps come when we should consider whether much more radical changes than those suggested are necessary not only in the method of nursing training, but in its length, its content and, what is more important, what it has to offer the nurse once she graduates....

So long as nursing service is required in return for nursing education this will remain the method of training....

Do we as nurses have sufficient educational opportunities to enable us to accept the additional responsibilities that the changing pattern of medical and nursing require? Do we...have the same educational opportunities as other professional people in the community?⁴⁴⁰

However vested interests of hospital boards, a conservative, patriarchal society, a tradition-bound nursing profession, and the strong role of the government mitigated against a radical re-think of nursing education and nursing practice.

⁴³⁹ Bridges, 1967, 213-214.

⁴⁴⁰ Cameron, 1955, 155-156.

Increasing influence of North American ideas on New Zealand nursing education

In *Paradise Reforged*, Belich describes the “decolonisation of collective identity” of New Zealanders.⁴⁴¹ Nursing was also caught in these tides of change. Jocelyn Keith and Judith Christensen discussed the commonalities among British, American and New Zealand nursing experience, noting the steady pull of New Zealand nurses towards American ideas, particularly in regard to approaches to nursing education.⁴⁴² While New Zealand nurses, in every era, were represented on international committees and were among those New Zealanders studying overseas, by the 1950s and 1960s, New Zealand nurses studying abroad increasingly chose to study in North America, rather than Britain.

Elsie Boyd, recipient of a British Commonwealth Scholarship in 1955 found her studies in the UK very disappointing,

Because it was a repetition of the course I had done at the Postgraduate School for Nurses...I did have the advantage of looking at hospitals' schools of nursing, but there was nothing new....So from the point of advancing my knowledge, it was a disappointment...Had I got that (scholarship) a little later I would have gone to Canada.⁴⁴³

In 1966, when she received a WHO Traveling Fellowship, Boyd went to the United States. She found it “fascinating because I looked at nursing programmes in universities and community colleges...and that was a very valuable experience for

⁴⁴¹ Belich, 2001, 392.

⁴⁴² Keith, J. (1989). The impact of American ideas on New Zealand nursing education: Part 1, The view from *The Journal*. In David Philips, Geoff Lealand & Geraldine McDonald ed. *The impact of American ideas on New Zealand's educational policy, practice and thinking*. (pp. 199-211). Wellington: NZ-US Educational Foundation. New Zealand Council for Educational Research.

Christensen, J. (1989) The impact of American ideas on New Zealand nursing education: Part 2, Change in New Zealand nursing education. . In David Philips, Geoff Lealand & Geraldine McDonald ed. *The impact of American ideas on New Zealand's educational policy, practice and thinking*. (pp. 212-218.). Wellington: NZ-US Educational Foundation. New Zealand Council for Educational Research.

⁴⁴³ Interview with E. Boyd, 30 August 2000.

me...”⁴⁴⁴ In the “Impressions and Observations” of her four-month study and experiences recorded in *Kai Tiaki*, Boyd drew comparisons and applications to the New Zealand scene relating to nursing education, nursing service, and statutory boards. With regard to nursing education, she commented:

Despite very valiant attempts by nursing leaders in this country, nursing education has made little significant progress for many years. It has struggled around inside a strangling framework. This framework or organisation is one that sees nursing service as being almost entirely reliant on student nurses.... If progress is to be made in this country, it is essential that nursing education takes its place as part of general education.⁴⁴⁵

Boyd noted that the vested interests of hospital schools of nursing, hospital administrators and the medical profession opposed such change, and delineated other reasons for the lack of progress:

The nursing profession as a whole is resistant to change because it is itself a product of a narrow task oriented training... (and) hospitals would need to replace the student nurses with registered nurses, registered community nurses and auxiliary workers. This would markedly increase the cost of hospital services.⁴⁴⁶

Later, during the campaign to achieve a transfer of nursing education from hospital service to education-based, Boyd recalled the success of American nursing arguments to politicians that hospital based programmes were in fact, expensive, rather than cost-saving. That this proved to be true in New Zealand, was “one persuasive point”.⁴⁴⁷

⁴⁴⁴ Interview with E. Boyd, 30 August 2000.

⁴⁴⁵ Boyd, E.A. (1967). Impressions and observations. *The New Zealand Nursing Journal*, Nov., 14.

⁴⁴⁶ Boyd, 1967, 14.

⁴⁴⁷ Christensen, 1989, 215.

University education for New Zealand nursing: Gathering momentum, finding resistance

In May 1959, at the NZRNA annual conference, Flora Cameron recalled her experiences at the ICN Education Committee meeting in March of that year.

I have come back inspired to inspire you to action. After all, we did have the first Registration Act in the world. Are we to remain as a developing country in nursing education and become one of the last to put nursing education in its proper place?... We need the university course to which our potential leader would be sent.....What we require is a Chair of Nursing in a university.⁴⁴⁸

This marked the beginning of more than a decade – from 1959 through 1972 - of persistent efforts to secure a nursing degree in New Zealand. The call began with the desire to establish a post-registration degree for future nursing leaders. However, over this period, other aspirations and ideas emerged. One view was that in addition to a post-registration degree for leadership (advanced) roles, there should also be an undergraduate pre-registration degree available to a select few. A few nurses began to see that the whole apprenticeship system of training could be eliminated.

Following Flora Cameron's address to the 1959 NZRNA annual conference, the Association took up the call. Minutes of an NZRNA "preliminary meeting set up to investigate ways and means of establishing a Chair of Nursing" indicate that among those attending were past and current employees of the Department of Health, including Mary Lambie, Flora Cameron, and Elizabeth Orbell.⁴⁴⁹ A plan was outlined to provide nurses with a series of articles on the proposal, and to lobby the Minister of Health. In fact, notes of a meeting held later that year with the Minister of Health explain that approaches to Victoria University regarding establishment of a post-registration programme in nursing had been made in 1956 by the Director-General of the Department of Health, Dr. Turbott and Miss Cameron. At that time Victoria University had noted its interest, but that it was unable to help.

⁴⁴⁸ Cameron, F.J. (1959). Nursing education: Address to annual conference, NZTRNA, Rotorua, May, 1959. *New Zealand Nursing Journal*, March, 74-75.

⁴⁴⁹ NA H, H-1, I-22, 33318, 1/11/25 Nursing training-university education for nurses.

The notes of the meeting of NZRNA representatives with the Minister of Health, H.G.R. Mason certainly do not outline a strong, or politically astute argument. In introducing the case, Margaret Pickard speaking for the NZRNA simply outlined nursing's development aims without a strong argument as to how these aims were critical to solving a particular problem in health. She explained:

they wanted to ask the Minister for his help in promoting a scheme which nurses had been working on since 1924 - a nursing course within the university for post-graduate nurses to prepare for leadership as tutors, matrons, senior public health nurses, etc...Over the last twenty years seventeen scholars had been sent away from New Zealand to get the sort of course that was now wanted here.⁴⁵⁰

Then, appealing to a government's stated desire for "more for less", Eileen Chambers, also speaking for NZRNA explained

When nurses went away from New Zealand they realized people in comparable positions had degrees and had far more opportunity to learn how to do their work quickly and efficiently so they could train the people under them. In New Zealand, nurses had to go into hospitals and find out by trial and error and do the best job they could.⁴⁵¹

Picking up the thread, Elizabeth Orbell noted she had been

Sent by the Government under the Columbo Plan in 1951 to instruct at the College of Nursing at New Delhi. She found they had a university course in nursing there for some six years. Certainly the Eastern countries were very

⁴⁵⁰ NA H, H-1, I-22, 33318, 1/11/25 Nursing training-university education for nurses. Notes of deputation from the New Zealand Registered Nurses' Association to the Minister of Health (Hon. H.G.R. Mason) at Parliament Buildings, Wellington, on Tuesday, 25 August 1959. M. Lythgoe (Pickard) was the National Secretary of NZRNA (1956-1964); E. chambers was the President of NZRNA (1956-1959); E. Orbell was an Instructor at the Postgraduate School for Nurses and Assistant Director, Division of Nursing, Department of Health.

⁴⁵¹ NA H, H-1, I-22, 33318, 1/11/25 Nursing training-university education for nurses. Ibid.

conscious of higher education, but at the same time they realized the great need for that higher education for their nursing administrators, and New Zealand nurses did feel their position when they went overseas,...

Following discussions with the Minister of Health, approval in principle was gained.⁴⁵³ But in requesting a university course, the nurses had not appreciated that the funds could not come from Vote Health, rather if they were to be approved, it would be via Vote Education and the University Grants Committee.⁴⁵⁴ It appears that nursing leaders had not fully appreciated the political complexities which could be brought to bear on their campaign. In 1960 the University Grants Committee declined to fund the Chair on the basis of the country's economic position.⁴⁵⁵

Nevertheless, Flora Cameron continued her policy entrepreneurship. The Division of Nursing, the Nurses and Midwives Board and the NZRNA worked together to secure the establishment of a degree programme for nursing. Again, in 1963, the Director-General of Health forwarded a paper on university education for nurses to the University Grants Committee.⁴⁵⁶ This extensive paper, developed by Beatrice Salmon, Principal of the Postgraduate School for Nurses/SANS outlined the current problems in nursing education and service, noted future trends, and proposed both a university-based post-basic diploma and a four-year pre-registration degree

⁴⁵² NA, H, H-1, I-22, 33318, 1/11/25, Notes of deputation from the NZRNA to the Minister of Health (Hon. H.G.R. Mason), 25 Aug 1959.

⁴⁵³ NA, H, H-1, I-22, 33318, 1/11/25, Notes of deputation from the NZRNA to the Minister of Health (Hon. H.G.R. Mason), 25 Aug 1959 and Establishment of Chair of Nursing approved, *Christchurch Star*, 2 Sept 1959.

⁴⁵⁴ Because nursing training had been established as a means of nursing service, it was wholly within the purview of the Department of Health and the governmental budget for health, referred to as Vote: Health. Flora Cameron subsequently sought seeding funding for a university programme from the Rockefeller Foundation. In her correspondence (21 December 1961) with Virginia Arnold, Assistant Director of the Rockefeller Foundation, Cameron explains "Although the Department of Health has endeavoured to assist in every way, it is unconstitutional for it to provide finance from Health which should come from Education." Funding from the Rockefeller Foundation did not eventuate. NA, H, H1, I-22, 33318 1/11/25 Nursing Training – University education for nurses.

⁴⁵⁵ Miller, N., 1984, 87.

⁴⁵⁶ NA, H, H-1, I-22, 33318, 1/11/25, Nursing training-university education for nurses. Letter from H.B. Turbot, Director-General of Health to Dr. F.J. Llewellyn, Chairman University Grants Committee, 2 Aug 1963.

programme for some minority of nurses, perhaps 5-20 percent over time.⁴⁵⁷ The University Grants Committee again declined.⁴⁵⁸

The Nurses and Midwives Board Curriculum Committee adopted *A Plan for Nursing in New Zealand* at its August 1964 meeting. The *Plan* called for basic nursing education to include three educational avenues by 1970: a degree programme; a general 3-year programme; and an 18-month community nurse programme.⁴⁵⁹ This proposal furthered the movement towards “comprehensive” nursing education, in that each of the three approaches to registration was to include maternal and child health, community health, psychiatric, and medical-surgical nursing.

Additionally, the *Plan* noted that “preparation of clinical experts, teachers, administrators, consultants and research workers” would be best met by the Postgraduate School for Nurses in conjunction with a yet to be established nursing department within a university.⁴⁶⁰ Certainly, where pre-registration education continued to be outside the mainstream of higher education, it must have been difficult to visualize post-basic or postgraduate nursing education. The Division of Nursing and the NZRNA continued to pursue the possibilities of both a “basic degree” and a post-registration degree for nursing, and throughout the early 1960s, university education for nursing was a constant topic at successive conferences.⁴⁶¹

⁴⁵⁷ NA, H, H-1, I-22, 33318, 1/11/25, Nursing training-university education for nurses. University Education for Nurses, Division of Nursing, 2 Aug 1963. No author is noted on this paper, however it is attributed to Beatrice Salmon in Carroll, P, Fieldhouse, A. & Shaw, S. (1983). *A profession in transition: Issues in nursing in New Zealand over two decades, 1961-1981, A selection from the writings of E. Beatrice Salmon*. Wellington: The C.L. Bailey Trust, 38.

⁴⁵⁸ Miller, N., 1984, 87.

⁴⁵⁹ NA, H-1, 22734, SANS, Nurses file-Dept of Health.

⁴⁶⁰ NA, H1, 22734 SANS Nurses file – Department of Health, p.3. Note also that SANS is still referred to as the Postgraduate School at this time.

⁴⁶¹ NA, H-1, 1/11/26, Letter from Shirley Lowe, Director, Division of Nursing to Alma Reid, Dec., 1966.
Miller, N.(1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses' Association, 86-91.

In the period 1965-1972, four major investigations related to nursing in New Zealand were conducted. These included the *Report on Nursing Education in New Zealand* (1965); the Department of Health *Review of Hospital and Related Services* (1969); the Carpenter report (1971); and the Department of Education report, *Nursing Education in New Zealand* (1972). Each of these reports had its genesis in the Department of Health, indicating the influence of the respective Directors of the Division of Nursing and the support of the Directors-General of Health, as well as the weight of political indifference in what has been described as an era of the status quo.⁴⁶²

These reports all highlighted similar problems. Each reads like an indictment. The shortcomings noted were small schools with inadequate learning experiences; a proliferation of categories of registration; a shortage of qualified nurse tutors; inadequate nursing libraries and other facilities for study; too many schools; priority given to nursing service over the students' learning needs; highly variable academic entry criteria; inadequate supervision and support for students over the three nursing shifts; and an average attrition rate of 45 percent.⁴⁶³ In no hospital was there a separate budget for nursing education.⁴⁶⁴

The *Report on Nursing Education in New Zealand* (1965) was authored by Alma Reid, Dean of the School of Nursing, McMaster University, Canada. The University Grants Committee (UGC) brought her to New Zealand "to assess the desirability and feasibility of introducing university nursing education in New Zealand, and to advise the University Grants Committee on this matter".⁴⁶⁵ The terms of reference for Reid's study visit had been developed by Victoria University.

⁴⁶² Gault, R. (2001). Health policy. In R. Miller, (Ed.) *New Zealand government and politics* (pp. 428-439). Auckland: Oxford University Press, 429.

⁴⁶³ Reid, A. (1965). *Report on nursing education in New Zealand*. Wellington: Whitcombe and Tombs, Ltd.
New Zealand Department of Health. (1969). *A review of hospital and related services in New Zealand*. Wellington: Author.
Carpenter, H. (1971). *World Health Organisation assignment report*. Wellington: Government Printer.
Department of Education. (1972). *Nursing education in New Zealand*. Wellington: Author.

⁴⁶⁴ Department of Health, 1969, 42.

⁴⁶⁵ Reid, 1965, 3.

The UGC's involvement had continued through Victoria University's on-going interest and involvement in nursing education at SANS, and particularly through the direct approach of Audrey Orbell, Director, Division of Nursing. In response to a query regarding nursing education at the post-graduate level, Orbell explained:

You will be aware that for some years before she retired, my predecessor [Flora Cameron] was endeavouring to have a programme for nurses established at university level. When I took over my present position I continued to pursue this avenue and with the consent of Dr. Turbott, Director General of Health, I was able to have discussions with Dr. Llewellyn who is Chariman of the University Grants Committee....After some discussion with Dr. Llewellyn he was instrumental in obtaining a Commonwealth Scholarship for a person to come to New Zealand and assess nursing for the University Grants Committee. The person who was to be awarded the scholarship had to be a nurse and herself a holder of a university degree. The scholarship was subsequently awarded and in June 1965, it is anticipated the holder will come and, so to speak, "do us over". I have no idea what her approach to her assignment will be, nor have I any direct information as to how the University have worded her assignment.⁴⁶⁶

Here Orbell's incomplete agency is striking. While she clearly sought to further the campaign for a degree in nursing, it would appear that Orbell lacked either drive, knowledge or political sophistication to ensure every step of this particular initiative was well-planned. Shirley Bohm was then a Nurse Advisor in the Division of Nursing. She commented:

Prior to my appointment, the Director of Nursing and those around her had worked very hard to try to get some better recognition for nursing education, and I inherited a situation where they had, through Victoria University, brought to New Zealand a consultant who was Alma Reid. And one of my first jobs was to escort her around...I felt very sad that here she was working

⁴⁶⁶ NA, H, HI, I-22, 33318, 1/11/25. Nursing training – university education for nurses. Letter from A. Orbell to Mrs. R. Archdall, 5 August 1964.

with this very restricted terms of reference...All the appointments had been made for her to go around New Zealand, but it was doomed to failure...we had all the wrong appointments...and we were powerless to change those terms of reference.⁴⁶⁷

Alma Reid's report was relatively brief, given that her terms of reference were limited to assessing the desirability and feasibility of introducing nursing education within the university system. She concluded that "university nursing education is indicated."⁴⁶⁸ However,

despite the fact that there was widespread support within the nursing profession and from the (NZRNA) for university education for nurses, despite the fact that she had visited all six universities and only one did not express immediate interest in the introduction of nursing to universities, and that her own belief was that there were "firm grounds" for introducing nursing to university, little eventuated from her visit or her report.⁴⁶⁹

While the Director-General of Health supported both a postgraduate and a "course in nursing science at the basic pre-registration level",⁴⁷⁰ and Victoria University's Vice-Chancellor, Dr. Williams and Professor C.L. Bailey⁴⁷¹ were supportive of at least a post-registration programme in nursing administration, the UGC declined to fund a Chair of Nursing.

It seems that more than money was at issue. Medical dominance and control were at stake, and deprecation and chauvinism were the responses. At the very least, conservatism ruled. In minutes of a meeting with Professor C. Lewis, Dean of the

⁴⁶⁷ Interview with S. Bohm, 25 March 2000.

⁴⁶⁸ Reid, 1965, 10.

⁴⁶⁹ Burgess, 1984, 74.

⁴⁷⁰ NA, H-1, 33320, 1/11/26, Notes of a meeting on university education for nurses, held in the office of the Chairman, University Grants Committee, 12 Sept.1966.

⁴⁷¹ C. L. Bailey, Professor of Education at Victoria University had been involved with SANS for many years. Alice Fieldhouse commented in an interview with me (8 June 2000) that "his mother was a nurse, and that, I think, sustained his interest in working with the School."

Medical School of Auckland University and several members of the Division of Nursing, Elsie Boyd recorded Professor Lewis' comments:

The Alma Reid report was not well received by the Auckland University Faculty. It was not considered to be a scholarly report. Professor Lewis has studied the report closely and shares the above view. Professor Lewis has...arrived at the conclusion that nursing education, for some, has a place within a university setting. (However), nurses must be aware that the medical profession as a whole does not consider that nursing education has a place in a university.....There has been published evidence of poorly conducted research in nursing in some nursing journals, and this has created an unfavourable impression.⁴⁷²

Other responses to the Reid report and initiatives for university education for nurses saw nursing education as a risk to the university. Rather than understanding that the current high attrition rate in nursing was largely a product of the combination of low entry criteria, lack of intellectual stimulation and a rigid, hierarchical system, Professor Bailey and others assumed the attrition rate was wholly due to gender,⁴⁷³ in spite of the fact that in his memorandum, Professor Bailey noted that "the overall (university) drop-out (in the sense of failing to graduate) is approximately fifty percent".⁴⁷⁴

Nevertheless, Professor Bailey was genuinely interested in university education for nursing, and continued to liaise with the Department of Health. Recalling that period, Alice Fieldhouse explained:

⁴⁷² NA, H, H-1, I-22, 33318, 1/11/25. Nursing training – university education for nurses. Minutes of meeting held in the rooms of the Medical council of New Zealand, Mayfair Chambers, Thursday 23 Nov 1967.

⁴⁷³ NA, H-1, 33320, 1/11/26, Comments on Miss Reid's report, from C.L. Bailey, Victoria University of Wellington, Department of Education, August 1966.
NA, H-1, 33320, 1/11/26, Notes of a meeting on university education for nurses, held in the office of the Chairman, University Grants Committee, 12 Sept.1966.

⁴⁷⁴ NA, H-1, 33320, 1/11/26, Comments on Miss Reid's report, from C.L. Bailey, Victoria University of Wellington, Department of Education, August 1966.

Professor Bailey had been involved for a long time in discussions with the Health Department on setting up a nursing programme within the university, and the Health Department always went along with this until the matter of how it was going to pay for it came up....Well, he got absolutely fed up with getting to this point with the Health Department. He couldn't get them to understand the quinquennial⁴⁷⁵ money...the funding was allocated on a quinquennial basis and universities wanting to introduce more programmes had to put forward their plans prior to the quinquennial...and the university colleges could challenge.⁴⁷⁶

In 1971, when nurses again feared that proposals for establishing nursing education within Victoria University might be lost, they established an independent trust to raise funds for a nursing "tutor in the university until a quinquennial grant could be achieved". In recognition of Professor Bailey's support, it was named the C. L. Bailey Nursing Education Trust was established.⁴⁷⁷

With hindsight it is evident that the Bailey Trust played a crucial ...role in ensuring the establishment of university programmes, for without its fund raising activities and donation of \$12,000 to Victoria University, plus the grant from NERF, proposals might once again have been rejected through lack of finance.⁴⁷⁸

But the purported reason for rejecting the Reid recommendation for university nursing education was that nursing was not a legitimate discipline. In his considerations of the Reid report, Professor Bailey regarded only the non-nursing courses in a "basic degree" for nursing as "academic".⁴⁷⁹ He noted "the New Zealand university

⁴⁷⁵ Quinquennial refers to a five-year administrative and funding period.

⁴⁷⁶ Interview with A. Fieldhouse 16 February 2001.

⁴⁷⁷ Interview with A. Fieldhouse 16 February 2001.
Miller, 1984, 90.

⁴⁷⁸ Miller, 1984, 90. NERF, the Nursing Education and Research Foundation had originated out of a memorial to Flora Cameron, who died in 1966.

⁴⁷⁹ NA, H-1, 33320, 1/11/26, Comments on Miss Reid's report, from C.L. Bailey, Victoria University of Wellington, Department of Education, August 1966.

system...is conservative in its relations with the quasi-professions, including teaching.”⁴⁸⁰ And in its opinion to the Director-General of Health, the University Grants Committee “came to the conclusion that it could not support a university teaching course which included ‘nursing’ as an undergraduate discipline in its own right”.⁴⁸¹

The challenging and frustrating times from the mid-1950s through the late 1960s were proving grounds for nurse leaders. There was no shortage of nursing policy entrepreneurs, but the system of nursing education and practice left most nurses unprepared for complex politics. The weight of medical dominance, social conservatism, expectations that women would marry and then leave the workforce, and a “growth in philosophical and political conservatism”⁴⁸² throughout the 1950s and into the 1960s were overwhelming forces. Nevertheless, valuable lessons had been learned.

In the latter half of the 1960s, while conservatism still ruled, societal shifts were developing. The oral contraceptive pill, nationally broadcast television, and jet air travel contributed to changing awareness, new ideas, information and freedoms. Protests were mounted over conservation issues, South African apartheid, and New Zealand’s involvement in the Vietnam war. Alcohol licensing laws and book censorship relaxed; New Zealand arts and culture began to assert a distinctly New Zealand character. Then, by the 1970s, “two broad but powerful forces coalesced from social and ideological seeds released in the late 1960s: the counter-culture and women’s movements”.⁴⁸³ The clash of conservatism and liberalism would be a tug-of-war. Reflecting on the changes in nursing education that eventuated during the

⁴⁸⁰ NA, H-1, 33320, 1/11/26, Comments on Miss Reid’s report, from C.L. Bailey, Victoria University of Wellington, Department of Education, August 1966.

⁴⁸¹ NA, H, H-1, I-22, 33318, 1/11/25 Nursing training-university education for nurses. University Grants committee memorandum for the Director-General of Health, 6 Sept 1967.

⁴⁸² King, M. (2003). *The Penguin history of New Zealand*. Auckland: Penguin Books, 414.

⁴⁸³ King, 2003, 459.

period 1973-1983, Yvonne Shadbolt comments, "The deeper changes, however, took place the decade before."⁴⁸⁴

The Carpenter Report and Operation Nurse Education

Shirley Bohm had been appointed Director of the Division of Nursing in 1966, inheriting the fall-out from the Reid report and the UGC. She went about planning to make changes to the work of the Division,⁴⁸⁵ and to achieve approval for a consultant to the Department of Health who would make recommendations on nursing education. In June 1970, Dr. Helen Carpenter, Director of the University of Toronto School of Nursing, took up her position as WHO Short-term Consultant to the New Zealand government.

Following her arrival, in consultation with the Director-General of the Department of Health, the Director and Assistant Directors in the Division of Nursing, and Principal of the School for Advanced Nursing Studies, and with agreement of the WHO, the original terms of reference were revised, giving more breadth and "teeth". For example, "to use the results of the evaluation to identify strengths and weaknesses in basic nursing education and to suggest changes which may lead to an increasingly effective programme", became "to make recommendations to Government with regard to the system of nursing education in light of the findings".⁴⁸⁶ Bohm commented:

⁴⁸⁴ Shadbolt, Y. (1983). Nursing education: A major shift. *The New Zealand Nursing Journal*. January (Jubilee Issue), 9.

⁴⁸⁵ NA, H-1, 33320, 1/11/26, Letter from Shirley Lowe (Bohm) to Alma Reid, 14 Dec 1966. Shirley comments in this letter about the "work study" done on the Division of Nursing, and the fact that although the work of the Nurses and Midwives Board is only "one of the seven objectives of the Division", it had almost "taken over". The Board was to eventually become independent of the Department.

⁴⁸⁶ Carpenter, H. (1971). *World Health Organisation assignment report*. Wellington: Government Printer, 8.: At the time of the Carpenter study, the Director-General of Health was Dr. D.P. Kennedy, the Director, Division of Nursing was Shirley Lowe Bohm, and the Assistant Directors of Nursing were Elsie Boyd, J. Sutherland and Nan Kinross. Beatrice Salmon was the Principal of the School for Advanced Nursing Studies (its name having been changed from the Postgraduate School for Nurses in April, 1970.)

We were working very, very hard ourselves to try to bring about change...but, I felt in the present climate, it was going to take someone from outside to come in and say what they thought because there weren't too many people in New Zealand who thought there was anything wrong with the existing system...[After] Helen Carpenter came, there were still quite bad days where, she wondered how on earth we were going to make progress.⁴⁸⁷

Dr. Carpenter's study drew on extensive "statistical and descriptive data from reports submitted by the hospitals, and observations made by the Division of Nursing, Department of Health, prepared in advance of the consultant's visit".⁴⁸⁸ This data was extended to include interviews with key individuals in health, education, professional associations, and hospitals. The study was further informed by a thorough review of literature on nursing and other health professional education, internationally and in New Zealand; and social and health trends and issues in New Zealand.

Dr. Carpenter filed her report with WHO in September 1970. This extensive report covered the factors leading up to the request for the WHO consultancy; a comprehensive review of the existing system of nursing education; social, educational and health trends of significance to the study; the findings of interviews with nursing students, nursing teachers, nursing service administrators, medical administrators and representatives of the medical profession, the executive boards of the New Zealand Hospital Boards' Association and the New Zealand Registered Nurses' Association; and representatives from the Department of Education, UGC, universities and technical institutes.

Among her recommendations were that suitably qualified nurses be appointed to various named New Zealand universities to develop one or more nursing subjects for registered nurses who enrol in these universities; to teach public health nursing and nursing service administration; and also undertake research in nursing. She also recommended that universities consider establishing a nursing programme "similar to the pharmacy course at the University of Otago and the nursing course at the

⁴⁸⁷ Interview with S. Bohm, 25 March 2000.

⁴⁸⁸ Carpenter, 1971, 17.

University of Edinburgh for university students who are interested in qualifying in nursing”.⁴⁸⁹ With regard to the existing system of nurse-apprenticeship training, she recommended that a nursing programme be established in a “college for the preparation of health services personnel established in an appropriate educational setting”⁴⁹⁰ in collaboration with hospitals and other health agencies in the area; and that when this programme had been successfully established, it be progressively developed in other regions with the concurrent phasing out of existing hospital schools of nursing.

The September and October issues of *Kai Tiaki* highlighted her findings and recommendations, continuing the dialogue about the inadequacies of New Zealand nursing education which had been prevalent in the journal throughout the previous fifteen years. The annual report of the Department of Health for the year ending March 1971, notes,

so far there has been an overwhelming response to this report (Carpenter). While there might be disagreement on some of the details of it, there is substantial agreement by all interested groups that major changes must be made in the system of nursing education.⁴⁹¹

In July 1971 the Minister of Education appointed a committee to consider recommendation 1.6 of the Carpenter report. Membership of the committee included three representatives each from the Department of Education and the Department of Health; three members representing the NZNA including one from the Student Nurses’ Association; two members from the Technical Institutes Association; and one each representing the University Vice-Chancellors’ Committee, Otago University Medical School, Hospital Boards Association, Medical Association, and the National Council of Women.⁴⁹² As recommended, the committee was,

⁴⁸⁹ Carpenter, 1971, 5.

⁴⁹⁰ Carpenter, 1971, 5.

⁴⁹¹ AJHR, 1971, H-31, 79.

⁴⁹² Members of the 1.6 committee were: W. L Renwick, Assistant Director of Education, Chairman; D.L Nelson, Director of Technical Education, Department of Education; B.W. Kings, Senior Inspector, Department of Education; E.G. Heggie, Deputy Director-General, Department of

to study the proposal for the development of colleges of health sciences for the preparation of nurses and other categories of personnel needed for the health services, and that this committee make recommendations to the Government concerning the most suitable educational setting for the development of these colleges.⁴⁹³

However, at its inaugural meeting the members of the committee decided that

our task was to consider appropriate educational and training programmes leading to registration as a nurses, and that we should study proposals for the development of colleges of health sciences only to the extent that our conclusions about the education of nurses might have implications for the other members of the health services.⁴⁹⁴

The committee became known as the “1.6 Committee”. Its report, *Nursing Education in New Zealand* detailed the considerations and conclusions of its nine meetings held between 29 October 1971 and 29 August 1972.

In this same period, New Zealand Nurses’ Association (NZNA)⁴⁹⁵ branches throughout the country discussed the Carpenter report, and by December 1971, *Kai Tiaki* reported support for the report by branches in Gore, North and South Otago, Southland, Marborough, Wellington, Hutt Valley, Gisborne, Middlemore and the Student Nurses’ Association. However, by June of the following year, nursing leaders

Health; E.A. Boyd, Assistant Director of Nursing, Department of Health; A.M. Fieldhouse, Nurse Instructor, School of Advanced Nursing Studies, Department of Health; A. Stewart, University Vice-Chancellors’ Committee; R.O.H. Irvine, Dean, Otago School of Medicine; J.A. Bateman and B.W Potter, Technical Institutes Association; J. Gardiner and P.M. Person, NZNA; J.M. Stewart, NZ Student Nurses’ Association; K. Glasgow, National Council of Women; and A.G. Wicks, Hospital Boards Association of NZ; G. Wynne-Jones, Medical Association of NZ.

⁴⁹³ Department of Education. (1972). *Nursing education in New Zealand*. Wellington: Author, 3.

⁴⁹⁴ Department of Education, 1972; The Carpenter report had noted that other health professionals, such as physiotherapists, occupational therapists, dieticians, and medical technologists were also concerned about their apprentice-style training, and expressed interest in the possibility of programmes being developed to be offered within an educational setting.

⁴⁹⁵ In 1971, NZRNA became the New Zealand Nurses’ Association.

feared momentum was being lost. Margaret Bazley, newly-elected President of NZNA launched "Operation Nurse Education". In letters to all branch secretaries and to all members, she noted

Your Executive is gravely concerned over the length of time Government is taking to make any change to the system of Nurse Education.....nearly eighteen months have passed since her report (Carpenter) was published and there is no sign of changes being initiated.

Telegrams and letters requesting change have been sent to Government and other organizations over a long period. Miss Burton (National NZNA Secretary) and I have recently seen the Ministers of Health and Education in an attempt to get some action and these approaches have resulted in some pressure being put on the committee to hasten its decision. It appears though that more needs to be done if change is to be implemented by 1973....

The New Zealand Nurses' Association demands that government establish at least one demonstration programme in 1973. "Operation Nurse Education" is the plan aimed at bringing sufficient pressure to bear on Government to ensure that this programme is implemented. I appeal to every nurse in New Zealand, whether student or registered, to stand united behind the New Zealand Nurses' Association until this demand is met.⁴⁹⁶

In August, Margaret Bazley's guest editorial in *Kai Tiaki* reiterated this call.

For almost 50 years the New Zealand Nurses' Association has been requesting changes in nurse education. Over the past 10 years very determined efforts have been made to have changes implemented. At successive conferences nurses have been unanimous in their support for change. This year NZNA has a plan – Operation Nurse Education- aimed at bringing pressure to bear on government to commence now for change to begin in 1973.

⁴⁹⁶ ATL 91-034-32/1 Nat Exec NZNA, Pres. Circ. 1972/1, 8 June 1972.

Suddenly it seems that nurses are frightened and confused. That thing that they have always given lip service to – improved nurse education – might become a reality. Their security is threatened. There are mutterings about militant action. Nurses, I am reminded, do not demand....⁴⁹⁷

On October 30, 1972 Cabinet approved the introduction in 1973 of the first three-year pilot comprehensive nursing programmes at Wellington Polytechnic and Christchurch Technical Institute, having approved nineteen of the twenty-one recommendations of the “1.6 Committee”⁴⁹⁸ Pilot programmes were established at Nelson Polytechnic and Auckland Technical Institute in 1974 and 1975, respectively. In 1976 the government approved the continued establishment of comprehensive programmes on an indefinite basis rather than a year-by-year approval process. By 1986, fourteen diploma programmes had been established, with the remaining hospital-based programme in Auckland closing in 1990.

How did it finally happen? What were the forces and voices behind this revolutionary change? A picture of New Zealand falling behind its North American cousins, a chronic nursing (student) shortage, high attrition rates, inadequate educational preparation, students being given responsibilities beyond their preparation, deficiencies in practice ---these problems had existed for fifty years.

On one hand, by the early 1970s, there was an appreciation among policy-makers that “all forms of education and training” should be under the auspices of education authorities.⁴⁹⁹ However, the “nurse as woman”, issues of control and power, and the revolutionary nature of the change were barriers. In 1960, New Zealand could be described as “a tight society....It was homogenous, conformist, masculist, egalitarian

⁴⁹⁷ Bazley, M. (1972). Stand up and be counted. *Kai Tiaki: The New Zealand Nursing Journal* 65(8), 3.

⁴⁹⁸ Department of Health, Circular Letter No. Hosp. 1972/232, 15 November 1972. Recommendations not approved were 2 and 7, which referred to the new programmes to prepare “general nurses”; and recommended that the new programmes be two and on-half years in length.

⁴⁹⁹ Department of Education. (1972). *Nursing education in New Zealand*. Wellington: Author, 11.

and monocultural, subject to heavy formal and informal regulation”.⁵⁰⁰ But a second wave of the women’s movement had been gathering momentum in the 1960s.⁵⁰¹ Where there had been “twenty or so”⁵⁰² new women’s organisations in the 1960s, approximately one hundred were formed in the 1970s. In 1972, the first National Women’s Liberation Conference was held, and the magazine *Broadsheet* was established. As the 1970s began, not only did the second wave of feminism rise powerfully, but it was accompanied by contestation across the broad waters of society. A cultural sea-change was to occur over the next few decades, involving not only women’s economic, social, political and personal rights, but also attitudes to racism, sexuality, religion, regulation, culture and nationhood.⁵⁰³ But first there would be the wars of words and will.

Yvonne Shadbolt was the inaugural Head of Nursing at Auckland Technical Institute (now Auckland University of Technology). She recalled

The opposing sides lined up with alacrity. The New Zealand Nurses’ Association gave unequivocal support to all of the recommendations and also secured the official support of the New Zealand Medical Association. . . . Hospital Boards, although admitting some reform was desirable, were quick to defend their schools of nursing and opposed any change that would remove students from the workforce. Individual nurses were quick to defend what had shaped them and expressed anger at what appeared to be criticism directed at them personally and professionally. Despite the official line of the Medical Association very few doctors expressed support. The majority endorsed the status quo, and many expressed concern at the prospect of “overeducated” nurses.⁵⁰⁴

⁵⁰⁰ Belich, 2001, 463.

⁵⁰¹ Macdonald, C. (ed.) (1993). *The vote, the pill and the demon drink: A history of feminist writing in New Zealand 1869-1993*. Wellington: Bridget Williams Books Limited, 143-160.

⁵⁰² Belich, 2001, 497.

⁵⁰³ Belich, 2001, 463-520.
King, 2003, 449-487.

⁵⁰⁴ Shadbolt Y. (1983). Nursing education: A major shift. *The New Zealand Nursing Journal*. January (Jubilee Issue),.9.

Those opposing the change were met, it seems, with considerable force. Recollecting that time, Dame Margaret Bazley, President of NZNA from 1972-74, and then Director, Division of Nursing from 1978-1987 commented:

It was an incredible battle. One of the most difficult battles I've ever been involved in because you were battling the – you know – the nurse being the handmaiden, the doctor being the boss of the nurse....To step out of line....And all over the country there was an uproar that nurses don't demand. And matrons forbade nurses putting it (the poster) up on their notice boards...there were meetings of hospital boards who were absolutely incensed that nurses would demand.

It was a very small group...perhaps a dozen, who were absolutely committed and who really did the battle....Shirley (Bohm) and Elsie (Boyd) worked day and night. Shirley was always in contact with me. Most people would never know we had a link. She would push it from her side and I would be pushing it from the Nurses' Association side...⁵⁰⁵

Elsie Boyd, Assistant Director for Nursing Education in the Division of Nursing at the time agreed that a relatively few people were leading the change, and that "Shirley Bohm really never got the credit she should have had, because without her drive, and her ability to get on very well with the Director General of Health, I think we would have been years longer".⁵⁰⁶ Dr. Douglas Kennedy, Director-General of the Department of Health was respected as a "visionary",⁵⁰⁷ and a "good ally".⁵⁰⁸ Shirley Bohm observed that,

⁵⁰⁵ Interview with M. Bazley, 18 May 2000.

⁵⁰⁶ Interview with E. Boyd, 30 August 2000.

⁵⁰⁷ Interview with M. Bazley, 18 May 2000.

⁵⁰⁸ Interview with S. Bohm, 25 March 2000.

I don't believe anyone other than myself will really realize the extent to which he was helpful....A person like that can be very influential....He had quite important positions at the World Health Organisation...Because he'd been with WHO he helped to get some money for consultants when I needed them...Dr. Kennedy...had some problems with his heart and a couple of times was admitted to Wellington Hospital....On one occasion he got his physician to phone me to say "come quickly"...I had to quiet him down...He was saying "I can see exactly what you mean. It's terrible; it's terrible."....He was very concerned.... "And you can get your consultant from overseas."⁵⁰⁹

Successive Annual Reports of the Department of Health demonstrate Director-General Kennedy's support in highlighting concerns in nursing education and its impact on practice. Excerpts from the 1968 Report note,

But as hospital nursing service becomes more complex and exacting, two factors give cause for more serious concern. Many nurses still continue to [be required] to supply expensive housekeeping, messenger, dietary and other services to the detriment of nursing service to patients, and a high percentage of the complex hospital nursing service in this country is supplied by student nurses. Only one-third of the nurses [sic] employed by hospital boards are registered nurses; forty percent are students and the remainder are hospital aides.

The formal preparation of public health nurses for their work continues to be a problem....demanding knowledge and skill well above that which can be provided in a service-based, hospital-oriented basic nursing programme.⁵¹⁰

The Annual Report for 1969 continues this line of argument:

In the days when the nurse was regarded as the doctor's handmaiden the high percentage of nursing service she gave while learning in a relatively simple

⁵⁰⁹ Interview with S. Bohm, 25 March 2000.

⁵¹⁰ AJHR, 1968, H-31, 64.

apprenticeship system gave hospitals much less cause for concern than it must today when a much higher degree of knowledge and skill is essential, and when a true apprenticeship system is no longer possible. The future success of our nursing service must be built on the concept of ...improvement in knowledge, in skill, in quality of service and in people. Is this possible while only 34.8 percent of those supplying the service are qualified...?⁵¹¹

Then in 1970, the Report notes,

The whole system of nursing education needs further careful study if responsible decisions are to be made with regard to its future. With this in mind the Department eagerly anticipates the report which will result from the joint decision of the Government and the World Health Organisation allowing part of this study to be undertaken in June 1970 by a short-term WHO consultant.⁵¹²

With regard to her own involvement in this dramatic change, Elsie Boyd commented,

these young and predominantly women were being used as a workforce and so nobody gave a hoot. Half of them failed along the way. But I can remember thinking morally that's wrong.... It was interesting because it was only, I suppose, our deep concern that made us give this advice to Government powerfully and strongly. Which is not easy always.... I felt like the Rawleigh's man taking the Carpenter report from North Cape to the Bluff...because people wanted to talk about it...what they really wanted was to have a stick at it you know....The heat that it generated was all out of proportion....⁵¹³

Dr. Nan Kinross was Assistant Director, Nursing Services in the Division of Nursing at that time, noted the strength of people in the Department of Health and NZNA.

⁵¹¹ AJHR, 1969, H-31, 67.

⁵¹² AJHR, 1970, H-31, 82.

⁵¹³ Interview with E. Boyd, 30 August 2000.

Shirley (Bohm) deliberately gathered around her these people ...they'd all had some sort of advanced programme. She gathered them in the Division. Now this I think was quite a brilliant move.... It was driven largely by Elsie and Shirley....We gradually built up momentum...very good use of the media. We got the doctors on side. The NZNA was on side....So you have the phenomenon of nursing education, - undergraduate education going into the polytechnics and of course the development of two post-basic programmes at university level – one at Massey and one at Victoria. Now it was no accident that that all happened. It was well orchestrated. It was well planned.⁵¹⁴

And so, while political will was perhaps tilting in favour of effecting a change in the way nursing education and nursing service were provided, it was by no means a forgone conclusion. Powerful allies in the Director-General of Health, the Division of Nursing, the NZNA, and the NZMA were essential. The voices of nursing leaders - primarily Shirley Bohm, Elsie Boyd, and Margaret Bazley - their policy entrepreneurship, leadership and political astuteness were critical.

Twenty-five years: 1973-1998 from diploma to degree as entry to practice

Ninety years elapsed from the establishment of the first hospital training programme in New Zealand in 1883, until 1973, when pre-registration nursing education had begun to be established in the tertiary education setting. It was another seventeen years before the last hospital-based programme closed in 1990. However, eight years later, New Zealand confirmed the bachelor's degree as entry to the register. Ironically, Australia, and then New Zealand achieved the bachelor's degree as entry to professional practice before the United States or the United Kingdom.

The change to nursing's educational preparation in the 1990s, in contrast to that of the 1970s, occurred largely by chance and opportunity. The Education Amendment Act (1990) created the New Zealand Qualifications Authority and established mechanisms

⁵¹⁴ Interview with N. Kinross, 19 April 2000.

through which tertiary education institutions, other than the universities, could grant degrees.

Nurses had not been instrumental in driving the passage of this act, but soon saw its opportunity, and the debate about the degree as entry to practice was rekindled. A consortium of nursing organizations, including the Nursing Council initiated a conference entitled: "Vision 2000: Project 1991", commissioned a discussion paper⁵¹⁵, and developed a framework for nursing education⁵¹⁶.

The debate was short-lived. By 1996, all institutes previously offering a pre-registration diploma had developed degree programmes. Advanced Diploma in Nursing programmes ceased, and increasing numbers of registered nurses commenced degree study. At its May 1998 meeting, the Nursing Council agreed that, allowing for existing diploma in comprehensive nursing programmes to phase out,⁵¹⁷ from 1998, entry to the register of comprehensive nurses would be via a bachelor degree. Nursing education leaders and others had seen the opportunity and seized the moment. Some nursing leaders were beginning to understand the new political discourse.

Conclusion

The period from the mid-1950s through the early 1970s was a challenge to New Zealand nursing. What had started out as an era of post-war nostalgia was swept away by the current of a changed world. Nursing had to develop new strengths.

A series of strong, visionary leaders in the Division of Nursing, NZNA and SANS worked collectively, progressively drawing in wider and wider networks. Flora Cameron, Shirley Bohm, Elsie Boyd, Nan Kinross, Margaret Bazley provided intelligent leadership. Margaret Bazley's and Shirley Bohm's individual policy

⁵¹⁵ Allen, N. (1992). *A framework for nursing and midwifery education in New Zealand: A discussion paper prepared for the Vision 2000 Committee*. Wellington: Vision 2000 Committee.

⁵¹⁶ Vision 2000 Committee. (1992). *A framework for nursing/midwifery education*. Wellington: Author.

⁵¹⁷ While all institutes were offering pre-registration degree programmes, there were one or two institutions, which at that time were still offering a "shortened diploma programme" for enrolled nurses to 'bridge' to comprehensive registration.

entrepreneurship and political sophistication enabled them to unite the profession, work effectively with policy makers and other key people, gather critical support from influential organizations, and guide their colleagues. As the flow shifted in favour of reforms, nursing was able to effectively advocate its case – advance its agenda. By gaining control of its educational processes, nursing could distance itself from medicine and the control of the hospital, develop its own standards of both education and practice.

The next chapter examines the governmental policy environment of the 1980s and early 1990s, the profound impact this had on the country's economic and socio-political environment, and consequent challenges to nursing.

Chapter 7: The 1990s - Strong forces, new voices, tensions and hostilities

Time is a violent torrent; no sooner is a thing brought to sight than it is swept by and another takes its place.

Marcus Aurelius, *Meditations*

Introduction

The changes in nursing education and practice occurring in the 1970s and early 1980s were revolutionary, but were progressively implemented against a backdrop of unfolding social change. In contrast, the nursing initiatives of the 1990s occurred in an era of radical socio-economic and public sector reform. The far-reaching changes in public policy of the late 1980s and 1990s were precipitously implemented, creating an unstable professional arena.

Reform of the health system, and eventually the whole of the state sector was accelerated by the Labour government in the mid-to late 1980s. Michael Bassett, a Labour Member of Parliament (and also a historian), described the Labour Party's appraisal of the situation:

[The] era of big government had largely been played out. The world economic downturn in the 1970s rendered further expensive extensions to the welfare state unaffordable, especially in New Zealand, where poor economic stewardship [had] caused the country to subside swiftly down the OECD performance ladder.⁵¹⁸

Labour was defeated by the National Party in the October 1990 election. Instead of a respite, National forged ahead with further reforms based on New Right theories of public-choice theory, agency theory and managerialism.⁵¹⁹

⁵¹⁸ King, M. (2003). *The Penguin history of New Zealand*. Auckland: Penguin Books, 490.

⁵¹⁹ Boston, J. (1991). The theoretical underpinnings of public sector restructuring in New Zealand. In J. Boston, J. Pallot, and P. Walsh. *Reshaping the state*. (pp. 213-238). Auckland: Oxford University Press.

The changes to nursing education and practice during the 1970s and 1980s, followed by changes to the state sector in the 1980s and 1990s, combined to create forces that radically altered dynamics and structures within the profession. The early years of the 1990s saw new professional nursing organisations being formed, challenging NZNA's position as the voice of the profession. Nursing leadership and practice structures were repeatedly reorganised and re-engineered. Initiatives in post-registration education were given momentum when a Clinical Training Agency (CTA) was established to fund post-registration clinical training programmes. Within five years of the first undergraduate degree programmes being established, the qualification for nursing entry-to-practice moved from diploma to degree.

The changes in nursing were both resultant to and derived from the reforms that swept through education, health and the wider social and economic context. This chapter explores the forces within this context that eventually came to bear on nursing's professional project, the development of "advanced nursing practice" and the Nurse Practitioner.

1980s: Stage-setting

If called upon to explain the comprehensive transformation of New Zealand between the 1960s and the 1990s, the word "1984" would occur to many. In that year, the reforming Labour government was elected. It proceeded to comprehensively restructure the New Zealand state and economy, in the direction known as "New Right," "neo-liberal," or "free-market". Its policies were continued, initially with enthusiasm, by the fourth National government of 1990-1999.⁵²⁰

However, many of these policies and subsequent changes had been foreshadowed. Derek Dow, in his history of the New Zealand Department of Health commented that "from 1972 onwards, health became more overtly politicized than ever".⁵²¹ During

⁵²⁰ Belich, J. (2001). *Paradise reformed: A history of the New Zealanders*. Auckland: Allen Lane: The Penguin Press. 394.

⁵²¹ Dow, D. (1995). *Safeguarding the public health: A history of the New Zealand Department of Health*. Wellington: Victoria University Press, 214.

the 1970s, efforts to reform the health sector “contributed to Labour’s defeat in December 1975”.⁵²² Nevertheless, the agenda set in the 1970s to improve management, and to establish more effective liaison between hospital boards and the Department of Health was to be regenerated in the 1980s. Furthermore, concerns about the allocation of funding to hospitals, both as a proportion of over all government spending and in relation to primary care, continued unabated throughout the 1980s.⁵²³

The Area Health Board Act (1983) signaled the new period of public sector reform. But much more was to come.

Through the statutory instruments of the State-Owned Enterprises Act 1986, the State Sector Act 1988, and the Public Finance Act 1989, and by reconfiguring the machinery of government, the fourth Labour government (1984-1990) transformed the structure, staffing and culture of the New Zealand public sector. The opportunity and motivation were provided, first, by the economic and fiscal crisis inherited by Labour, and secondly, as a result of the perceived performance of the public sector itself.⁵²⁴

While Labour “increasingly scrutinized the health sector”, commissioning reviews of the health system, it “refrained from radical reform.”⁵²⁵

Seven months after its December 1990 election, “and despite its promises to the contrary”,⁵²⁶ the incoming National government released its intentions to radically reform New Zealand’s health care system.

⁵²² Dow, 1995, 216.

⁵²³ Gauld, 2001, 430.
Dow, 1995, 220-221.

⁵²⁴ Martin, J. (2001). The public service. In R. Miller, (Ed.) *New Zealand government and politics* (pp. 132-144). Auckland: Oxford University Press, 133.

⁵²⁵ Gauld, 2001, 430.

⁵²⁶ Finlayson, M. (1996). An analysis of the implementation of health policy in New Zealand 1991-1996. Thesis, Ph.D., University of Waikato, 96.

By 1990 New Zealand's health care system, strongly influenced by the local-central relationship governing hospitals, the power and influence of the medical profession, and the increasing expectation that government subsidised health care services should be available as of right, contained many structural anomalies. There was no central planning for health service provision. Area Health Boards continued to provide services themselves rather than purchase them from other providers where it would have been more efficient to do so....and Area Health Boards had conflicting roles....The system was fragmented...In their attempt to grapple with these problems, the fourth Labour government introduced changes to increase efficiency and effectiveness of the Area Health Boards. The National government however, was not prepared to allow time to see if the changes would have the desired effect.⁵²⁷

Speed was of the essence. Elected Area Health Boards were immediately disestablished, and the next few years saw the establishment of a National Interim Provider Board, Regional Health Boards, Crown Health Enterprises, the Public Health Commission, and the National Advisory Committee on Core Health Services. Nursing voice and leadership within the Department of Health was largely silenced; nursing leadership and management within the health sector was dismantled; and the relationships among NZNA, the Nursing Council, educators, practitioners, and nurse managers changed significantly as a result of these reforms.

The Department, the Council and NZNA: Altered relationships

The close association among the Division of Nursing, the Nurses and Midwives Board and the NZNA had its origins in the early years of New Zealand nursing history. With the passage of the Nurses Registration Act (1901), responsibility for nursing registration sat within the Department of Health. When Hester Maclean, as Assistant Inspector for Hospitals, Asylums and Charitable Institutions, founded *Kai Tiaki* in 1908, and the New Zealand Trained Nurses Association in 1909, the stage was set for an intertwining of roles and responsibilities relating to nursing education, registration,

⁵²⁷ Finlayson, 1996, 97.

nursing service and professional standards and communication. Elements of this arrangement were to endure for over eighty years. While the tripartite relationship among the Division of Nursing, the Nurses and Midwives Board and the NZNA had begun to change with the passage of the 1971 Nurses Act, the effect of their long-standing overlap of roles was apparent for decades to come.

The Nurses Act 1971 established the Nursing Council of New Zealand⁵²⁸ as a body corporate outside the Department of Health. However, the Director, Division of Nursing, was still an ex officio member of the Council. In their book celebrating the centenary of nursing registration in New Zealand, editors Pamela Wood and Elaine Papps comment that “the Department appeared reluctant to relinquish its regulatory role. Nurses within the Department had to redefine their function. It seemed that letting go of their past role involved, understandably, a degree of grieving”.⁵²⁹

For the Nurses’ Association, the loss of its long affiliation with the Nursing Council and the Division of Nursing in the Department of Health was perhaps even more painful and confusing. Shirley Bohm, Director of the Division of Nursing 1966-1979, commented that when she was appointed Director,

I found myself Registrar of the Nursing Council (then the Nursing and Midwives Board) with responsibility for, under the Act, signing every registration certificate that...went out. Signing with my own hand. So it was a matter of changing legislation to get some sense into all this. Prior to my appointment, the Nurses’ Association and the Division of Nursing and the Nursing Council were firmly united as almost one group, and one of my jobs was to separate these three groups to get on with their own work.... I have to say that having got these three groups separated, the Nurses Association was particularly free to...become much more influential out on their own....

⁵²⁸ The Nursing Council which replaced the Nurses and Midwives Board was still responsible for both nursing and midwifery, although its name only reflected nursing.

⁵²⁹ Wood, P.J. & Papps, E. (2001). *Safety to practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*. Wellington: Nursing Council of New Zealand, 120.

There were some Presidents....There was Margaret Bazley who I had quite a bit to do with. She was President during the 1970 period and very unthreatened by the fact that I wanted it all to be separate. I would say she was the first person who could see clearly that the Nurses' Association must do its thing; the Department must do its thing; and the Council must do its thing. I never fully got the Council out on its own before I left....The Nurses' Association became stronger and did its own thing, but there were times when they sort of wanted to climb back into the bed....And they would ask to do something crazy like take over Nursing Council.⁵³⁰

Anne Nightingale, Chairperson of the Nursing Council from 1975-1984 reflected on the pressure from NZNA and other groups:

The Nurses' Association was top of the list. You always had to go to the Nurses' Association conference every year. It always felt like a ream of questions that you had to stand up and answer....The Principal Nurses were another group.⁵³¹

Allison Chappell, Nursing Council Chairperson from 1987 through 1990 also noted that she frequently had to explain to various groups "what was the difference between the Nursing Council, the Nurses' Association and the Department of Health, and what were their roles".⁵³² The misunderstandings created by this historic overlap and eventual undoing created tensions, conflict, and made it difficult for the profession to work from a collective agenda.

The effects of the political and structural changes in relationships between NZNA, the Department of Health and Nursing Council were exacerbated by the reforms of the late-1980s and early 1990s. Allison Chappell commented on her experience of this as Chairperson of Nursing Council.

⁵³⁰ Interview with S. Bohm 25 March 2000.

⁵³¹ Wood, P.J. & Papps, E. (2001). *Safety to practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*. Wellington: Nursing Council of New Zealand, 52-53.

⁵³² Wood & Papps, 2001, 83.

In those years 1987, 1988, and 1989, the Chairperson and the Chief Executive would be invited to the Nurses' Association annual conference. We would be given front row seats and microphones and asked to comment on many of the things that happened. By 1990 when they restructured, we were invited in but sat right at the back as observers and certainly not given microphones and were lucky if we were acknowledged as being present.⁵³³

The health sector reforms of 1980s attempted to alter the power-base in the sector. While in part, a drive to reduce medical dominance, the reforms succeeded in diminishing all clinical leadership, including nursing, for some time. Medical dominance in the Department of Health had been criticized since at least the 1960s.⁵³⁴ However, it was not until 1986 that the Health Act was amended to remove the requirement for the Director-General to be a medical doctor, as well as the requirement for three-fourths of the divisional directors to be doctors. The Director-General of Health, John Martin commented,

In 1986, we broke the baronies, I hope, by getting rid of the doctors as heads of divisions, and having the Sally Shaws (Director of Nursing since June 1984) and other people coming through the doors with the doctors beneath them and so forth.⁵³⁵

A corporate management group was formed, and the Department was restructured to allow it "to respond more flexibly to changing health needs".⁵³⁶ In a paper presented to the International Council of Nurses, Sally Shaw explored the changes to the Department of Health.⁵³⁷

⁵³³ Woods & Papps, 2001, 83.

⁵³⁴ Dow, 1995, 208.

⁵³⁵ Dow, 1995, 210.

⁵³⁶ Dow, 1995, 210.

⁵³⁷ Shaw, S. (1989). Nurses in management: New challenges, new opportunities. Paper used as the basis for a presentation to the Plenary Session on Nurses' Leadership: beyond the Boundaries of Nursing *International Council of Nurses Quadrennial Congress*. Seoul, Korea.

Many saw it then, ... as a simple de-medicalising of senior management positions in the Department of Health. It was clear at that time that the structure...was going to undergo some change, and it was clear that the Division of Nursing...and the position of Director, Division of Nursing, would be unlikely to remain as they were.

Staff of the Division of Nursing planned a careful and pro-active strategy. The essence of this was to clearly identify what the function of nursing in central government was, and to package it in such a way it could be argued for during the forthcoming debates and discussions on change...To find a way of ensuring that this role continued at central government level...The focus was on the purpose, function and contribution of nursing rather than on positions and structure....

During 1986 the change took place...the position of Director of Nursing was changed to Chief Nursing Advisor....This has ensured the continuation of an important leadership role in nursing.....however, there were, and still are, many others who... consider that nursing has somehow lost out in the process.⁵³⁸

Nursing was unprepared. Throughout 1987 a number of seminars, workshops and conferences for nurses on changes to the health system and nursing leadership development were held. However, "in March 1988, after having been introduced unexpectedly and largely unpredictably only in December 1987, State Sector legislation was passed. This brought about profound changes to the health service."⁵³⁹

The State Sector Act (1988), which ushered in general management, required the Nurses' Association to register as a union. Many nurses saw the State Sector Act as a betrayal. The *New Zealand Nursing Journal/Kai Tiaki* editors described it as "a piece

⁵³⁸ Shaw, S. (1989). Nurses in management: New challenges, new opportunities. Paper used as the basis for a presentation to the Plenary Session on Nurses' Leadership: beyond the Boundaries of Nursing *International Council of Nurses Quadrennial Congress*. Seoul, Korea.

⁵³⁹ Shaw, 1989.

of legislation which many believed to be designed to undermine the whole concept of the welfare state, including threats to nurses' jobs and working conditions".⁵⁴⁰ This focus on jobs and conditions was a relatively new phenomenon for NZNA. It was not until 1969 that the Association won the right to formally negotiate salaries and conditions for nurses.⁵⁴¹ The State Sector Act, its associated philosophical and theoretical underpinnings, and the restructuring of the health sector together significantly contributed to nurses' sense of confusion and chaos in the late 1980s.

However, a more serious challenge came with the passage of the Employment Contracts Act 1991. According to Belich, this Act "left no place for trade unions. Union membership halved from 45 percent of the workforce in 1989 to 23 percent in 1993."⁵⁴² The passage of the Employment Contracts Act exacerbated NZNA's hostility to Government, and added further fuel to the union fire. The Nurses Amendment Act 1999 unraveled the last thread of NZNA's special relationship with the Department of Health. This Act eliminated NZNA's sole right to nominate the nurse and midwife members to the Minister of Health for appointment to the Nursing Council. It also removed the Chief Nurse Advisor, Ministry of Health from Council membership.

In the changed and charged environment of the late 1980s through the early 1990s, the range of professional objectives of the NZNA became overtaken by its "industrial" concerns.⁵⁴³ Nursing leadership structures in hospitals and area health boards had been dismantled by the general management approach, and the voice of clinical

⁵⁴⁰ Ten years of our time: A review of nursing in the 1980s. (1989). *New Zealand Nursing Journal*, December, 8.

⁵⁴¹ Burgess, M. (1984). *Nursing in New Zealand society*. Auckland: Longman Paul, 142. The State Services Conditions of Employment Act 1969 recognised the NZNA as the negotiating body for nurses in the public sector. Under that legislation, it was not possible for NZNA to also represent nurses in the private sector. In 1993, NZNA and the Nurses Union, which represented private sector nurses, amalgamated. This amalgamated organisation became the New Zealand Nurses' Organisation.

⁵⁴² Belich, 2001, 411.

⁵⁴³ Hine, S. (1997). Promoting a professional profile. *Kai Tiaki Nursing New Zealand*, March, 11. Stodart, K. (1991). No time for division. *New Zealand Nursing Journal*, August, 2. Ten years of our time: A review of nursing in the 1980s. (1989). *New Zealand Nursing Journal*, December, 7.

nursing struggled to be heard.⁵⁴⁴ In spite of nursing education being sited within the tertiary education sector, opportunities for further nursing education were limited. A nursing community, which had been bounded by the Division of Nursing and NZNA up to the mid-1980s, was by early 1990s, in a situation where the Division had disappeared, and NZNA was embattled. Familiar structures and strategic alliances were crumbling. The Department, the Nursing Council and NZNA no longer shared a broad collective agenda.

Vision 2000: Project 1991 - Conflict and chaos

The idea of a national forum to develop policy for nursing and midwifery education had been initiated at the 1990 NZNA annual conference, when a group of nurse educators, chief nurses, Department of Health, Nursing Council and NZNA representatives got together to discuss the implications of the Education Amendment Act 1990.⁵⁴⁵ Nursing Council was asked to facilitate the development of a forum, and the planning committee became known as the Vision 2000 Committee. While NZNA played a key role in the planning and promulgation of the Vision 2000: Project 1991 Forum, *Kai Tiaki* was relatively quiet on the subject of degree education for nurses throughout this time. This was in stark contrast to the dialogue surrounding the Carpenter report. Much had changed in twenty years.

Nurse educators were no longer part of the hospital “family” of nurse-employees. Nursing students were no longer the critical requirement for the delivery of patient care. This distancing, of course, enabled true educational programmes to be developed, and permitted the profession to advance its professional project. But among some practising nurses, the distancing also created grief and anger over the loss of their control over education. It most likely also created a sense of being

⁵⁴⁴ Carryer, J. (1995). Invisible regulation. *Nursing Praxis in New Zealand*, 10(2), 4-12.
Keene, L. (1994/95). Nurses’ perspectives missing. *Nursing New Zealand*, December/January, 10.
Lynch, C. (1990). Charge nurse in a critical setting. *New Zealand Nursing Journal*, August, 16-17.

⁵⁴⁵ Personal communication dated 5 October 1990 from M. Burgess, Registrar/Executive director Nursing Council of New Zealand. The Vision 2000 Committee was comprised of Marie Burgess, Nursing Council; Beryl Davies, NZ College of Midwives; Ray Wootton, Susan Jacobs, Merian Litchfield, and Margaret Horsburgh, NETS; Joy Bickley, NZNA; Sheryl Smail, Department of Health; Denise Hutchins, Chief Nurses’ Assoc.

devalued. Two cultural communities of nurses were developing what was unhelpfully portrayed in the literature as the “theory-practice gap”.⁵⁴⁶ The wave of state sector reforms made it particularly difficult to build a bridge between these cultural communities. This was to become particularly apparent in the dialogue regarding a degree for pre-registration nursing education.

A degree in nursing had been a goal for New Zealand nursing since the 1920s. Two post-registration degree programmes were eventually offered at Victoria and Massey universities, commencing in 1973. In the late 1980s, nursing was not anticipating that the nature of polytechnics would change. What was wanted by many in nursing was greater recognition of the polytechnic diploma towards credit in a nursing degree.⁵⁴⁷ However the *Review of the Preparation and Initial Employment of Nurses* also noted

There is awareness of an emerging need for a bachelor’s degree in nursing, conducted in conjunction with a registration programme. Until the transfer of nursing education to technical institutes is completed and well established, availability of this option for entry into the nursing profession will remain premature.⁵⁴⁸

Nevertheless, as late as 1991, NZNA’s proposed clinical career structure reflected the limited opportunity for degree education for nurses, and suggested that the polytechnic-based Advanced Diploma in Nursing “would support a more expanded scope of practice.”⁵⁴⁹

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- ⁵⁴⁶ Department of Health. (1986). *Review of the preparation and initial employment of nurses*. Wellington: Author, 19-21.
Landers, M.G. (2000). The theory-practice gap in nursing: The role of the nurse teacher. *Journal of Advanced Nursing* 32(6), 1550-1556.
New kids on the block. (2003). *New Zealand Nursing Review*, November, 10,12.
- ⁵⁴⁷ Department of Health. (1986). *Review of the preparation and initial employment of nurses*. Wellington: Author, 54.
- ⁵⁴⁸ Department of Health, 1986, 54.
- ⁵⁴⁹ NZNA (1991). *A proposal for career development for nurses in clinical practice*. Wellington: Author, 8.

Public sector reform did not impact on tertiary education until 1987, when “Treasury’s ...post-election briefing papers – a rather extraordinary, two-volume, 700-page document – dedicated an entire volume to education.”⁵⁵⁰ Treasury envisaged the extension of the New Right, free-market ideology to public education. Government commissioned a review of tertiary education by Professor Gary Hawke, from the Institute of Policy Studies at Victoria University. The Hawke Report, released in September 1988 proposed a tertiary sector where functional differentiation between polytechnics, universities, colleges of education and wananga⁵⁵¹ was blurred, and where granting degrees was not limited to the universities. The Education Act 1989 and subsequent 1989/90 amendments brought this scenario to fruition.

With the passage of the Education Amendment Act 1990, the prevailing questions were: 1) should nursing develop a pre-registration degree; and 2) should all nurses be prepared by degree qualification? In one of the few articles published in *Kai Tiaki* regarding the possibility of polytechnic degrees, Margaret Horsburgh put the case,

There is no debate that nurses should have degree preparation. We have fought long and hard for degree programmes for registered nurses, but there is some reluctance in some quarters for New Zealand to follow the worldwide trend of baccalaureate preparation for all registered nurses. For me, the question is not should our nurses be prepared for starting practice at a baccalaureate level, but rather how many should be....

To suggest that preparation at degree level is only appropriate once a nurse has completed a rigorous three-year programme of study is completely inequitable....Other vocational and health professional groups don’t even have this argument, yet in nursing there seems to be an expectation that nurses must tread a long and arduous path before they can receive degrees.....⁵⁵²

⁵⁵⁰ Kelsey, J. (2001). Tertiary education policy. In R. Miller, R. (Ed.) *New Zealand government and politics*. (pp. 440-451) Auckland: Oxford University Press, 442.

⁵⁵¹ Wananga is a Maori word for places of learning.

⁵⁵² Horsburgh, M. (Dec/Jan 1990/91). Polytech by degrees. *NZNJ*, 27.

Toward the end of her article, Horsburgh predicted, "It seems unlikely that every polytechnic will wish to offer a degree programme". How wrong she was. By 1996, every polytechnic which previously had been offering a diploma in nursing was now offering a nursing degree. If every nurse educator did not believe that the degree was the appropriate education for entry-to-practice, then the market advised differently. As one polytechnic chief executive put it, "If my son or daughter was thinking of becoming a nurse, and there was a choice between a diploma or a degree programme, I know which I'd be advising."⁵⁵³

Before the Vision 2000: Project 1991 Forum was held, three institutions, Otago Polytechnic, the Auckland Institute of Technology, and Wellington Polytechnic were already developing their degree programmes. At the end of that year, each had received New Zealand Qualifications Authority approval and accreditation.⁵⁵⁴

The two-day forum was held in March 1991, with its report being published in May. The forum had attracted approximately 260 participants⁵⁵⁵ from a wide cross-section of nursing. However, as a whole, the participants were not able to focus on key issues to be considered in relation to the opportunity presented by the Education Amendment Act, let alone develop a consensus on pre-registration nursing education. This is perhaps not surprising, given the extent of social, economic and state sector reform that had been occurring.

While the forum was intended to provide the context for the identification of issues, what emerged were predominantly concerns. Many of these have been

⁵⁵³ Personal communication, 1993, John Rose, CEO, Hawke's Bay Polytechnic.

⁵⁵⁴ Nursing by degrees: three polytechnics prepare for 1992. *NZNJ*, Dec/Jan, 1991/1992, 25. Otago Polytechnic's programme was a three-year degree, while the Auckland Institute of Technology and Wellington Polytechnic had developed four-year degrees. Within a year of approval, the Department of Education advised it would not fund the fourth year of a pre-registration nursing degree. Both AIT and Wellington Polytechnic revised their programmes to three-year degrees.

⁵⁵⁵ Vision 2000 Committee. (1991). *Vision 2000: Project 1991 forum report 14/15 March*. Wellington: NZNA on behalf of the organising committee of Vision 2000: Project 1991, 2.

raised consistently over many years, and have been conscientiously addressed by national groups and other interested nurses.⁵⁵⁶

This comment from the Forum report rather gently notes that the concerns raised were old chestnuts. The concerns raised did not focus on the opportunity at hand, but were wide-ranging - from protection of the enrolled nurse, issues relating to the “comprehensive course”, “developing advanced nursing knowledge and practice”, fostering research, the place of midwifery in relation to nursing, “bicultural issues and autonomous Maori development”, relationships and communication among education, practice, communities, universities and polytechnics, and diploma versus degree.⁵⁵⁷ Overall, the Forum participants seemed to be caught in a whirlpool.

The report then recommended to the Vision 2000 Committee that “a nationally oriented group to provide direction and action for nursing and midwifery education be established” in order to address a range of matters, including “identification of the educational preparation required by nurses and midwives to meet the health needs of New Zealanders”.⁵⁵⁸ The forum report cried out for national consensus-building. For example, among the areas suggested for a national group to address were:

- provision of short and long term plans for nursing and midwifery to meet the health service needs of the clients; ...
- provision of a means by which issues of national concern for nursing and midwifery can be addressed; ...
- exploration of possible formats to consider nursing and midwifery issues on a long-term basis.⁵⁵⁹

⁵⁵⁶ Vision 2000 Committee. (1991). *Vision 2000: Project 1991 forum report 14/15 March*. Wellington: NZNA on behalf of the organising committee of Vision 2000: Project 1991, 2.

⁵⁵⁷ The Vision 2000 Committee had organised for a small group of people to participate in a “day 3 of the forum. Their task was to utilise effectively and fairly the views and information generated in the previous two days”, and to “produce a document expressing a national framework for nursing and midwifery education...” (from the Notes of Meeting of Wellington members of the Planning Group held 17 Jan 1991).

⁵⁵⁸ Vision 2000 Committee. (1991). *Vision 2000: Project 1991 forum report 14/15 March*. Wellington: NZNA on behalf of the organising committee of Vision 2000: Project 1991 7.

⁵⁵⁹ Vision 2000 Committee. (1991). *Vision 2000: Project 1991 forum report 14/15 March*. Wellington: NZNA on behalf of the organising committee of Vision 2000: Project 1991 7.

In order to progress the dialogue initiated by the forum, the Vision 2000 Committee commissioned a discussion paper.⁵⁶⁰ However, by the time the discussion paper was published, six months later, events had already overtaken it. Three pre-registration degrees had been approved: one three-year degree and two four-year degrees.

NZNA rejected Natali Allen's discussion paper primarily on the grounds that the report recommended the "eventual end of enrolled nursing".⁵⁶¹ Among her twenty-two recommendations were three that NZNA rejected because of "current NZNA policy" relating to support and development of enrolled nursing.⁵⁶² These three recommendations were:

- That by the year 2005, a four-year baccalaureate degree be the sole criterion for entry to nursing and midwifery practice. NZNA opposes this on two grounds—it presupposes abolition of second-level nurse preparation; also...a three-year degree is suggested.
- That the role of the enrolled nurse be reviewed with an emphasis on potential for future employment.
- That in 1996 the Nursing Council cease to accept applications for the Roll of Nurses. NZNA opposes these recommendations. NZNA believes the enrolled nurse plays an essential part in the provision of nursing care...⁵⁶³

At that time, enrolled nurses would have constituted twenty to twenty-two percent of NZNA's membership.⁵⁶⁴ By December 1992, when the Vision 2000 Committee published the *Framework for Nursing/Midwifery Education*, the approach had been

⁵⁶⁰ Allen, N. (1992). *A framework for nursing and midwifery education in New Zealand: A discussion paper prepared for the Vision 2000 Committee*. Wellington: Vision 2000 Committee.

⁵⁶¹ Enrolled nurses angered. *NZMJ*, May, 1992, 23.

⁵⁶² (1992). The Vision 2000 report and NZNA's response. *NZMJ*, May, 23.

⁵⁶³ (1992). The Vision 2000 report and NZNA's response. *NZMJ*, May, 23.

⁵⁶⁴ Department of Health. (1986). *Review of the preparation and initial employment of nurses*. Wellington: Author, 105.

The percentage of E.N.s noted above is derived from 1980 and 1984 numbers of registered and enrolled nurses holding annual practising certificates. The proportion of E.N.s grew from 21.5% in 1980, to 22.1% in 1984, and by 1992, it is unlikely that this proportion would have changed significantly. Programmes preparing E.N.s began to decline by the early 1990s.

modified. The recommendation to close the Roll had been softened to recommend that Nursing Council review the advisability of continuing the Roll. The degree remained the recommended qualification for entry to the register, but the Vision 2000 Committee's Framework was silent on whether this degree should be a four-year or three-year degree, and the timeframe for fully implementing the pre-registration degree had been brought forward to 1997.⁵⁶⁵

Nevertheless, the conversations did occur at local and regional levels as nursing leaders within the polytechnic system consulted within their educational institutions, advisory committees and communities, and gained support for this new opportunity. By 1996 every pre-registration diploma programme had been replaced by a three-year degree.

What was revealed in the Vision 2000: Project 1991 Forum, its report, discussion paper and ensuing responses was a profession divided, in competition with one another, and in some chaos. There had been no long exploratory "lead-up" to the vision of degree preparation for entry-to-practice. In some regions, diploma programmes had only relatively recently replaced the hospital programmes. NZNA's consideration of the degree was clouded by a union issue. Nurse educators, who might have been expected to develop a consensus position on the three- versus four-year degree, failed to do so. Could the Nursing Council have promulgated a position on the degree for entry-to-practice as a matter of public safety as it did later with post-registration clinical education?

Lost in an era of "hit and run" comprehensive financial, public sector and social change, the nursing voices were scattered. Perhaps after decades of hierarchical decision-making, members of the profession were divided between those shocked and paralysed by lack of central decision-making for the profession and those who felt unrestrained, buoyed by opportunity and in some cases, comfortable in an environment of intraprofessional competition.

⁵⁶⁵ Vision 2000 Committee. (1992). *A framework for nursing/midwifery education*. Wellington: Author.

Nursing organizations and leadership: New forces, new voices

From its religious, military and Victorian origins, nursing was shaped and dominated by hierarchical structures and lines of authority. Apprentice-style training reinforced these strictures and limited the development of individual leadership. In a small country like New Zealand, for many years, the nursing community was relatively small. “Shoulder-tapping” for leadership development predominated. The Postgraduate School for Nurses/School for Advanced Nursing Studies (SANS) provided further education primarily for the “select few”.

For most of the twentieth century, nursing power and leadership was vested in the Division of Nursing. Given the Division’s direct links with SANS and the Nurses and Midwives Board, and the close affiliation of the Division with NZNA, nurses could be expected to look to the Division and to NZNA for professional leadership, direction, and decision-making. From the 1970s, this nursing leadership alliance was progressively undone. The reforms of the late 1980s/early’90s fractionated the profession. In the late 1980s and early 1990s, long-standing associations continued to adapt their focus, while new professional organizations emerged.⁵⁶⁶ This mix of players brought a new dynamic to the voices of the profession.

By 1990, nursing education heads of department had begun to organise their own network and formal meetings. Historically, nursing education concerns had been addressed through the Department of Health, committees of NZNA, and to some degree, the Nursing Council. With the transfer of nursing education from Health to Education, the Department of Education appointed staff specifically for this new area of the department’s concern, and continued the pattern of organising meetings of nursing education heads of department to discuss matters of nursing education policy and practice. The reforms of the late 1980s-early 1990s were seeing the elimination of these positions in the Department. An organisation primarily of nursing heads of

⁵⁶⁶ These new organisations included the College of Midwives, Te Kaunahera O Nga Neehi Maori O Aotearoa (National Council of Maori Nurses), Nurse Educators in the Tertiary Sector, the College of Nurses Aotearoa, and the Australia and New Zealand College of Mental Health Nurses. Except for the College of Midwives, these are discussed in this section.

department, Nurse Education in the Tertiary Sector (NETS), was officially established in 1992.⁵⁶⁷

At the Vision 2000: Project 1991 Forum held in March 1991, one of the discussion groups shared thoughts about the declining leadership of NZNA in professional concerns, as opposed to employment issues. An impromptu meeting was called for the end of the day to discuss these concerns with NZNA officers. It was a frank and collegial discussion, but NZNA remained convinced it was satisfactorily addressing the professional leadership issues for nursing.⁵⁶⁸ However, for others, this seemed not to be the case.

Many senior nursing leaders in the public health sector had lost their positions during reforms and restructuring, and had felt unsupported by NZNA. Nurse educators, similarly, felt that NZNA was not meeting their professional needs.⁵⁶⁹ Nan Kinross, an active and long-time member of NZNA explained,

...I'd been on every committee that the NZNA had, including the Executive. I had been a member of the Economic Welfare Group and also involved on the professional side for NZNA, therefore I felt very strongly that both sides should be developed. By 1990 the NZNA had changed greatly and it seemed to me that they were no longer as interested in nursing scholarship as they should have been, in fact, they seemed not interested in professional issues at all.⁵⁷⁰

Following the discussion at the Forum in March 1991, a workshop was held later that year to gauge support for a "professional college of nursing",⁵⁷¹ with emphasis on

⁵⁶⁷ [Http://www.moh.govt.nz/moh.nsf/wpg](http://www.moh.govt.nz/moh.nsf/wpg). Nursing in New Zealand. Accessed 20/04/2003/

⁵⁶⁸ I was present at this workshop and subsequent discussion.

⁵⁶⁹ Williams, B. G. (2000). The primacy of the nurse in New Zealand 1960s-1990s: Attitudes, beliefs, and responses over time. Ph.D. thesis, Victoria University of Wellington, 129.

⁵⁷⁰ Adams, K. (2003). A postmodern/poststructural exploration of the discursive formation of professional nursing in New Zealand 1940-2000. Ph.D. thesis, Victoria University of Wellington, 281.

⁵⁷¹ Adams, 2003, 281.

“professional” as opposed to “union” activities.⁵⁷² This led to the establishment, in 1992, of the College of Nurses Aotearoa (NZ), an organization for registered nurses only, with no union or collective bargaining focus.⁵⁷³ Led by its founding President, Jenny Carryer, this new organization was to have a significant effect in its first decade.

NZNA had provided for special interest sections since 1972.⁵⁷⁴ However over time, some specialty areas felt the need for a stronger specialty-focused organization. Frances Hughes, then a manager of mental health services, initiated, and became the founding president of the Australia and New Zealand College of Mental Health Nurses (ANZCMHN) in 1993.⁵⁷⁵ Through Frances Hughes, the ANZCMHN was to initiate a new era of post-registration nursing education.

Born out of the earlier Matrons’/Chief Nurses’ Association, Nurse Executives of New Zealand (NENZ) extended its membership to include not only the most senior nurses in the Crown Health Enterprises (CHE), but also those of other “major health provider organizations and the senior nurse employed in each of the Department of Corrections, Ministry of Defence, Department of Occupational Safety and Health and the Ministry of Health.”⁵⁷⁶

In 1993, the Nurses’ Union, representing nurses in the private sector, amalgamated with NZNA to form the New Zealand Nurses’ Organisation (NZNO). Then in the mid-1990s NZNO considered that it should become a “nursing/midwifery and allied

Kathryn Adams’ thesis traces the inception and development of the College in detail.

⁵⁷² Allen, 1992, 29.

⁵⁷³ Editorial. (1991). No time for division. *New Zealand Nursing Journal*, August, 2. NZNA membership included enrolled nurses and nursing aides, later health assistants.

⁵⁷⁴ Miller, N. (1984). Post-basic nursing education. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses’ Association 1909-1983* (pp79-93). Wellington: New Zealand Nurses’ Association, 93.

⁵⁷⁵ Manchester, A. (1998a). In the forefront of change. *Kai Tiaki*, March, 11. Interview with F. Hughes 22 October 2002.

⁵⁷⁶ [Http://www.moh.govt.nz/moh.nsf/wpg](http://www.moh.govt.nz/moh.nsf/wpg). Nursing in New Zealand. Accessed 20/04/2003

health workers' organisation representing as many health workers as possible".⁵⁷⁷ The "nurses' organisation" soon spoke for not only two types of nurses with significantly different educational backgrounds and practice jurisdictions – enrolled nurses and registered nurses - NZNO also came to include in its membership untrained and unregulated caregivers. While a range of health workers is essential to the health services, this broad membership meant that issues of concern to registered nurse-members of NZNO, other than salary and conditions of employment, were inevitably sidelined. In 1988, NZNA was the predominant, perhaps unquestioned voice of the profession. By 1998, NZNO was radically altered in its position.

Conclusion

These voices and forces were fundamental to the discourse of the 1990s, an era typified by upheaval, a sense of loss, tensions, and at times, frank intra-professional hostility. The competing discourses included those of general managerialism, efficiencies, markets and cost-effectiveness; unsafe staffing, redundancies and deskilling; nursing theory, scholarship and professionalism. In this unstable professional environment, the "advanced nursing practice" movement emerged in the mid-to-late 1990s. The next chapter examines the policy and political environment of this period from which a challenge to medicine's jurisdiction emerged, and the changing state of the profession's political sophistication.

⁵⁷⁷ Viewpoint: One health union? (1994/5) *Nursing New Zealand*, December/January, 16.

Chapter 8: The development of advanced nursing practice in the 1990s

While many nurses have criticised or bemoaned the lack of progress in clinical development in some areas, we need to be reminded that the nurse in New Zealand has a very recent history of a focus on clinical practice with the Registered Nurse as the primary provider of care.⁵⁷⁸

Introduction

In December 2001, Deborah Harris became New Zealand's first Nurse Practitioner,⁵⁷⁹ described as "a registered nurse practicing at an advanced practice level, who has been prepared at Masters level of education and has been recognized and approved by the Nursing Council".⁵⁸⁰ This milestone in the development of advanced nursing practice in New Zealand was achieved on the centenary year of New Zealand nursing registration, but less than a decade after the first pre-registration nursing degrees were approved.

By the late 1990s, factors in nursing education and practice, population health, and government policy were conducive to this development. Nursing education for entry-to-practice had been confirmed as an undergraduate degree. A Ministerial Taskforce on Nursing had determined that there were barriers to nurses providing "effective and innovative service" and to nursing developing its potential.⁵⁸¹ Access to primary health care, integration of health services and the rate of improvement in health status within segments of the population were persistent concerns.⁵⁸² In response to health needs, and barriers to meeting them, two successive Ministers of Health demonstrated

⁵⁷⁸ Williams, B. G. (2000). The primacy of the nurse in New Zealand 1960s-1990s: Attitudes, beliefs, and responses over time. Ph.D. thesis, Victoria University of Wellington, 129.

⁵⁷⁹ Cassie, F. (2002). One of a kind. *New Zealand Nursing Review*, April, 7-8.

⁵⁸⁰ Nursing Council of New Zealand. (2001b). *The Nurse Practitioner™: Responding to health needs in New Zealand*. Wellington: Author, 9.

⁵⁸¹ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 7.

⁵⁸² Ministry of Health. (1996). *Healthy New Zealanders: Briefing papers for the Minister of Health 1996*. Wellington: Author.

support of legislative and policy initiatives that could enable nurses to more effectively deliver primary health care and other specialist nursing services.⁵⁸³

This array of factors was conducive to policy, legislative and funding changes which would enable expansion in nursing's practice jurisdiction and the underpinning educational pathways to support such changes. However, in spite of this favourable environment, the development of what was being termed "advanced nursing practice" was by no means assured. In particular, efforts to expand nursing jurisdiction into legitimated diagnosis and treatment, including prescribing, were met with anticipated inter-professional jurisdictional disputes. However, what was perhaps not well anticipated were the intra-professional conflicts. This chapter examines initiatives to support nursing practice development, and the forces which came into play in response to them.

Post-registration nursing education and support for the development of clinical practice

By the mid 1990s, with the bachelor degree secured as the qualification for entry-to-practice, new types of post-registration programmes needed to be developed. Previously, formal post-registration programmes included the one-year SANS diploma, with emphasis on either teaching, administration or public health nursing, which was offered from 1928 to 1978; apprentice-style specialty-area courses offered from 1948 to 2000;⁵⁸⁴ and advanced diploma programmes or similar programmes with some specialty-area content, which were phased out as bachelor degree programmes were established. Nursing studies were established at Victoria and Massey universities in 1973, with masters and doctoral degrees eventuating.⁵⁸⁵

⁵⁸³ Minister outlines opportunities for nurses. (1997). *Kai Tiaki: Nursing New Zealand*, October, 13. Manchester, A. (1998). Nurses gain right to prescribe. *Kai Tiaki: Nursing New Zealand*, June.12. Ministry of Health. (2002). *Nursing Sector Update*. August. Wellington: Author. Ministry of Health. (2004). *Nursing in New Zealand*. Retrieved 12 June 2005 from http://www.moh.govt.nz.nsf/wpg_Nursing+About+Us

⁵⁸⁴ It is believed that the last apprentice-style specialty programme was the Intensive Care Nursing course offered by the Hawke's Bay District Health Board.

⁵⁸⁵ Salmon, E. B. (1981). New Zealand universities and nursing education: The first seven decades. In P. Carroll, A. Fieldhouse, S. Shaw (Ed.) (1983). *A profession in transition*. (pp.60-64). Wellington: The C.L. Bailey Nursing Education Trust.

However, while many would argue that the existing masters programmes did provide advanced preparation for clinical practice, others viewed those programmes as primarily preparation for nursing education, administration or research.⁵⁸⁶ This was a legacy of the belief that the content of nursing is mastered in basic nursing education, and through years of practice. No doubt accurate of nursing knowledge in its early years, this view had certainly not been true since at least the development of social sciences, post World War II developments in science and technology, and the emergence of nursing research in the 1950s. Reflecting on a similar history in the United States, Virginia Cleland noted that there had been

several decades in which faculties of nursing programs in universities prepared only educators and administrators. Most often there was little or no further education provided for the practice of nursing....The exclusion of clinical courses and the overemphasis upon teaching methodology and administrative science led many in the profession to devalue the practice of nursing....and to give its greatest rewards to teachers and administrators rather than to practitioners.⁵⁸⁷

In New Zealand, where various elements of nursing practice had been absent from general hospital-based training, these areas were often addressed via a post-registration programme which was, again, apprenticeship in its nature. For example, Plunket training provided a focus on the well infant and child. Community health and public health nursing were also largely lacking in hospital-based programmes until the late 1940s and 1950s.⁵⁸⁸ The fifth year of the proposed University of Otago nursing programme was planned to provide education in public health nursing, and subsequently the Postgraduate School for Nurses/School for Advanced Nursing Studies (SANS) addressed this need. Chapter Three discussed how these clinical

⁵⁸⁶ Allen, 1992, 69.

⁵⁸⁷ Cleland, V. (1972). Nurse clinicians and nurse specialist: An overview. In *Three challenges to the nursing profession: Selected papers from the ANA convention*. (pp.13-25). American Nurses' Association, 14.

⁵⁸⁸ Cameron, F.J. (1954). Trends in nursing overseas. *The New Zealand Nursing Journal*, August, 132.
Cameron, F.J. (1956). Address by Miss F.J. Cameron, OBE on the new curriculum: 1956 Conference of Training School Matrons. *The New Zealand Nursing Journal*, June, 111.

practice areas were seen as “advanced” because they were areas of nursing theory and practice which were excluded from the hospital-focused programmes.

While the Advanced Diploma in Nursing (A.D.N.) programmes, discussed in Chapter Three, provided for study in areas traditionally seen as advanced clinical areas, e.g. midwifery, community health, and maternal-child health, some A.D.N. programmes also offered a focus on “medical-surgical” nursing. However, as discussed, the A.D.N. programmes, only available in selected institutes, and requiring one-year full-time on-site study, lasted little more than a decade.

Attempts to provide impetus and support for the development of clinical nursing practice was evident in the NZNA publication *New Directions in Post-Basic Education* (1976). But with rather limited opportunities for further nursing education, and the transition from apprenticeship basic education to formal tertiary education stretching out from 1973 to 1990, it seems there was minimal support for the development of clinical practice. From their 1982 study of post-basic nursing education, King, Fletcher and Callon noted

...it is apparent that post-basic courses for registered nurses have assumed many forms in a relatively short period of time. It may be many years before the consequences of the multiple basic programmes cease to have an effect at the post-basic level.⁵⁸⁹

Thirteen years after its document on post-basic education, NZNA established a certification process by which “registered nurses ...[with] a combination of advanced education, experience and demonstrated clinical excellence...[could] apply for professional recognition.”⁵⁹⁰ Explaining its purpose for the certification process, NZNA maintained that,

⁵⁸⁹ King, B.E., Fletcher, M.P. & Callon, L.G. (1982). *Post-basic nursing education in New Zealand*. Wellington: Department of Health, 13.

⁵⁹⁰ Upping standards. (1989). *New Zealand Nursing Journal*, October, 21.

As the professional organization for New Zealand nurses the NZNA is primarily concerned with the standard of nursing care provided to the public. Through certification the NZNA is able to meet part of that obligation by ensuring that those nurses who are offering specialist and expert services are in fact well qualified to do so. It is expected that advanced clinical positions will eventually be included within the award.⁵⁹¹

Two categories of certification, Nurse Clinician and Nurse Consultant, were available. However, it was a voluntary process, having no relationship to entitlement to practice as a specialist, and thus, not endorsed by the Nursing Council or national public sector employer-body such as the Hospital Board Association. It was perhaps, an idea before its time.

Within five years, NZNA was questioning the demand for and appropriateness of this service. Exploring the demand for a professional accreditation process, the now, New Zealand Nurses' Organisation⁵⁹² noted that the certification service for its members was "underused".⁵⁹³ NZNO itself, was also questioning whether there might be a conflict of interest created when an organization with both a "union" and a professional focus accredits practitioners' competence.⁵⁹⁴ It was noted that

Providing an accreditation service may strengthen NZNO's position as the major nurses' body in the country. It would also have the potential to create a conflict of interest for NZNO – between a standards monitoring role and an industrial advocacy role.

Such a conflict would not exist... in Canada, where nurses' professional and regulatory bodies are in the same organization, and a separate nurses' union looks

⁵⁹¹ Upping standards. (1989). *New Zealand Nursing Journal*, October, 21.
The "award" refers to what was then a nationally-negotiated employment agreement between NZNA and public employers of nurses.

⁵⁹² In 1993 NZNA and the Nurses' Union which represented nurses in the private sector, amalgamated forming NZNO.

⁵⁹³ Stodart, K. (1994/95) Why get accredited? *Nursing New Zealand*, December/January, 11.

⁵⁹⁴ Stodart, 1994/95.

after their industrial interests. In New Zealand, the professional and industrial functions are both within NZNO and the regulatory function in a separate body, the Nursing Council.⁵⁹⁵

Interestingly, this argument appears to have been forgotten by NZNO when it entered into a conflict with other members of the Ministerial Taskforce on Nursing over the Taskforce's recommendation that the Nursing Council develop the standards for, and credential advanced nursing practitioners.⁵⁹⁶

In 1991, NZNA released *A Proposal for Career Development for Nurses in Clinical Practice*.⁵⁹⁷ The paper's focus on clinical practice argued that while nursing management, education and research are critical to the on-going development of the profession, it is at the clinical practice interface where nursing delivers on its contract with society. It noted that career structures for clinical practice had been discussed since the late 1970s, with the view that such a focus on clinical practice development could help to develop nursing practice; ensure responsive and effective nursing service delivery; provide acknowledgement of excellence in practice; and thereby ensure career satisfaction.⁵⁹⁸ Nevertheless, bringing the concept to "reality has been a slow process".⁵⁹⁹

This proposal was a framework describing five levels of nursing practice, termed "Nurse", level 1 through level 5, based on experience, education, complexity of practice role and setting, and clinical leadership.⁶⁰⁰ However, the document acknowledged that feedback on various drafts indicated that further education as a criterion for career advancement was a sticking point.

⁵⁹⁵ Stodart, 1994/95.

⁵⁹⁶ Wilson, B. (1998). NZNO and the Taskforce. *Kai Tiaki: Nursing New Zealand* 4,(7),2. New Zealand Nurses Organisation. (1998). *Building partnerships: Developing the future of nursing*. Wellington: Author, 5-6.

⁵⁹⁷ New Zealand Nurses' Association. (1991). *A Proposal for Career Development for Nurses in Clinical Practice*. Wellington: Author.

⁵⁹⁸ NZNA, 1991, 1.

⁵⁹⁹ NZNA, 1991, 1.

⁶⁰⁰ NZNA, 1991, 2-3.

The shape of the structure was less acceptable to many, principally because of a mis-perception that educational qualifications were the principal criterion for movement in this structure. There was anxiety lest experience and the major contribution from nurses without formal qualifications be devalued. This is not the intent of a structure which must acknowledge complementarity in practice if it is to have any effect on client well-being. Nevertheless, conscious decisions and choices are implicit in the idea of career development. To deny that formal studies can make a difference in clinical practice is to argue in favour of nurses (female, in particular) being born, not made.⁶⁰¹

Clinical career ladders were progressively introduced throughout the country during the 1990s, and were greeted with limited and distracted enthusiasm. As we have seen, a torrent of public sector reforms swept the country with the election of the National-led government in 1990.

Policy entrepreneurship for clinical practice development

The public sector restructuring of the 1990s included changes to the funding and provision of post-registration nursing education. This exacerbated the lack of support for more clinically-focused post-registration education. Ministry of Education funding for post-registration nursing programmes was provided only to “academic” programmes, with specified limits on clinical hours.

A new funding body, the Clinical Training Agency (CTA) was established to fund post-entry continuing education on a national basis following the 1992 “unbundling” of clinical education costs within the health sector.⁶⁰² However, the funds reallocated from the Crown Health Enterprises, (which had replaced area health boards), to the CTA, were found to be a “serious underestimate of the cost of training and education”

⁶⁰¹ NZNA, 1991, i-ii.

⁶⁰² Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 52. Post entry clinical education was defined as “training that is vocational, clinical, post-entry, formal, a minimum of six months and nationally recognized.” Ministry of Health. (2002). *Clinical Training Agency strategic intentions 2003-2012*. Wellington: Author.

that had been provided.⁶⁰³ Furthermore, since the funds had been historically committed to physician education, this pattern was continued.⁶⁰⁴ In 1996, ninety percent of the initial \$44 million budget was used for medical post-entry programmes, while the remaining ten percent was allocated for programmes for nursing and allied health professions.⁶⁰⁵

In the mid-1990s, opportunities for further education in nursing were an eclectic mix of old and new. Some Crown Health Enterprises continued to provide in-house apprentice-style specialty programmes, such as intensive care nursing or neonatal nursing. The advanced diploma in nursing programmes offered by polytechnics since the mid-1970s had disappeared. Victoria University no longer offered its undergraduate nursing degree, but now offered masters and doctor of philosophy degrees in nursing. Massey University offered post-registration bachelor, master, and PhD in nursing degrees. Since the advent of polytechnic-based nursing degrees, increasing numbers of registered nurses were studying toward an undergraduate nursing degree, and there was the anticipation that more nurses would be studying at an advanced level.⁶⁰⁶

In 1994-95, Frances Hughes, then a Director of Mental Health at Capital and Coast Crown Health Enterprise, sought funding for a clinically-based post-registration nursing programme to assist new graduates develop further specialty knowledge and

⁶⁰³ CAPE. (1997a). *Towards a strategy for the education and training for the health and disability support sector: A discussion document*. Wellington: Committee Advising on Professional Education, 18.

⁶⁰⁴ CAPE. (1997b). *Education and development of the health and disability workforce*. Wellington: Committee Advising on Professional Education, 11.

⁶⁰⁵ CAPE, 1997a, 18-19.

⁶⁰⁶ Nursing Council's first survey of registered nurses' educational qualifications was published in 2000. [Nursing Council of New Zealand. (2000). *New Zealand registered nurses, midwives and enrolled nurses: Survey of educational qualifications*. Wellington: Author.] This survey (which achieved a 71% response rate), indicated that at 1999, of 31,801 registered nurse-respondents, 5774 (18.2%) held a bachelors degree; 213 (0.7%) held a master's; and 16 (0.15) held a doctorate.

By 2002, [Nursing Council of New Zealand. (2004). *New Zealand registered nurses, midwives and enrolled nurses: Workforce statistics 2002*. Wellington: Author.] 6,070 registered nurses held a bachelor's as their first nursing qualification, with a further 4000 (nurses and midwives) having been awarded their bachelor's degree in nursing as a post-registration qualification. 851 held a master's degree; and 53 held doctorates.

skills for mental health nursing.⁶⁰⁷ As the proposed post-registration programme was to be substantially clinically-based, Health rather than Education funding was required. Frances Hughes noted:

Someone in the HFA/RHA (Health Funding Authority/Regional Funding Authority) in Wellington agreed to fund it until the CTA got established...And so in 1995 we established the new graduate programme in mental health....We were using the first lot of CTA funding. I wrote the specifications...at the CTA. We had no professional (nursing) oversight. I was really concerned. I wrote to the Nursing Council. I was President of the ANZ [Australia and New Zealand] College of Mental Health Nursing, but we couldn't do it....We had leadership in the college, but not the resources....Putting the Nursing Council there, at least it gave it a chance that the profession would look at it. If the profession went down this track with advanced practice with the new graduate, at least it gave it a chance to be picked up.⁶⁰⁸

This was one of the developments that gave impetus to the Nursing Council developing and promoting a post-registration nursing education framework. The nursing education framework developed by the Vision 2000 Committee in 1992⁶⁰⁹ had arisen out of a focus on education for entry-to-practice, and had been necessarily broad given the era during which it was developed. The new emphasis was on knowledge development for specialist and advanced practice, and a need for a coherent framework.

Frances Hughes saw the potential problem of further *ad hoc* post-registration nursing programmes being developed. While she coupled the problem with a possible ready-solution and larger policy direction, others saw the situation differently. Frances recalled her discussions with the Nursing Council:

⁶⁰⁷ Interview with F. Hughes 22 October 2002.

⁶⁰⁸ Interview with F. Hughes 22 October 2002.

⁶⁰⁹ Vision 2000 Committee. (1992). *A framework for nursing/midwifery education*. Wellington: Author.

I remember going to the Nursing Council and being absolutely poorly treated. Jill White (then Professor of Nursing and Midwifery at Victoria University) and I presented this new framework—about this new graduate and an advanced framework. What we wanted was for the Council to approve it—we knew there was going to be funding around it....They said there was no difference between mental health than any other nurses. That nurses needed no special preparation. – “What were the competencies that were different?” They thought we were saying polytechnic training was no good.... But I had a belief...I mean it wasn't just their ...lack of knowledge about advanced practice, but it was also how they were inadvertently impeding it.⁶¹⁰

In 1997 Hughes found herself, as the new Nurse Advisor in the Ministry of Health, a member of the Nursing Council. Within a few years, the policy potential of a framework for clinically-focused post-registration nursing education, with such programmes having the sanction of nursing's statutory body had become apparent to the Council and others.⁶¹¹

In 1996 Nurse Education in the Tertiary Sector (NETS) and Nurse Executives of New Zealand (NENZ) collaborated to develop a position statement and post-registration education pathway which was subsequently ratified by both organizations in 1997.⁶¹² At the same time, in order to provide a professional framework for CTA-funded nursing programmes, as sought by Hughes, the Nursing Council was beginning work on standards for post-registration programmes, including differentiation of “advanced” nursing practice.⁶¹³ Following rounds of consultation, several drafts, and

⁶¹⁰ Interview with F. Hughes 22 October 2002.

⁶¹¹ Ministry of Health. (undated). *Criteria for purchase of post-entry clinical training*. Christchurch: Clinical Training Agency.
Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author.

⁶¹² NETS/NENZ. (1997). *Position statement: Post-registration nursing education*. Author.: Members of the working party which developed the position paper were Chris Andrews (NENZ), Frances Hughes (NENZ), Maureen Laws (NENZ), Eve McMahon (NETS), Margaret Southwick (NETS), and Jill White (NETS).

⁶¹³ Nursing Council of New Zealand, 1998, 3.

submissions involving key stakeholders, Nursing Council finalized its *Framework, Guidelines and Competencies for Post-registration Nursing Education* (1998).

In defining advanced nursing practice, the Nursing Council drew from the Canadian Nurses' Association definition:

Advanced nursing practice has a clinical/therapeutic focus. It is the integration of “research-based theory and expert nursing in a clinical practice area, and combines the roles of practitioner, teacher, consultant and researcher”⁶¹⁴ to advance the professional practice of nursing.

By the time the Framework was adopted, the Minister of Health had established a Taskforce on Nursing; and the Nursing Council noted “there appears to be political will to extend prescribing rights to registered nurses in the future.”⁶¹⁵

Nurse-prescribing

In 1992, as part of the wider health reforms, Government considered a paper on occupational regulation of the core health professions. This was a joint project by the Ministry of Health, Health Reforms Directorate and the National Interim Provider Board. One of the issues covered in that paper was that of extending prescribing rights for nurses. It was argued that this would provide the public with choice as to the source of health care and produce efficiency gains.... Extending prescribing rights to nurses could increase efficiency by providing access to health care which might otherwise be unavailable; potentially reducing pharmaceutical costs as nurses tend to use

⁶¹⁴ Canadian Nurses' Association. (1997). Out in front-Advanced nursing practice. In *Nursing Now-Issues and Trends in Canadian Nursing*, 2, Jan. cited in Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author, 10.

⁶¹⁵ Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author, 6.

other therapeutic approaches before drugs, (the recent experience from expanding prescribing rights to midwives has demonstrated this effect).⁶¹⁶

A discussion paper by John Shaw, Associate Professor in the School of Pharmacy, University of Otago, on the possible extension of prescribing rights to nurses and other health professional groups was commissioned by the Ministry of Health in 1994. It followed other work related to extension of prescribing, and explored precedents for nurse-prescribing in the United Kingdom, Australia, and the United States. Following its publication, the discussion on nurse-prescribing seemed to go quiet. Then in 1996 further work on nurse-prescribing began.⁶¹⁷

Frances Hughes was appointed as a nursing advisor in the Ministry of Health in 1996.

I didn't come in and say "What are we doing about it?" I was asked – it was fascinating...within two months I was asked if I would chair these groups. I was quite low down in the echelon to do that. I think it was part of the wider scheme of things...There was a lot of furore from the medics. But there was always a great deal of support from both administrations. The National Government was very supportive of it. I don't think the Ministry particularly was—because it was taking on the doctors.⁶¹⁸

Nevertheless, things were progressed. A working party to explore matters relating to safety and quality in extending prescribing rights was convened, and its report was published November 1997.⁶¹⁹ A few months later, on February 23, 1998, the Minister of Health, Bill English, established a Ministerial Taskforce on Nursing

⁶¹⁶ Shaw, J. (1994). *Prescribing rights in New Zealand: A public discussion paper*. Wellington: Ministry of Health, 8-9.

⁶¹⁷ Interview with F. Hughes 22 October 2002.

⁶¹⁸ Interview with F. Hughes 22 October 2002.

⁶¹⁹ Ministry of Health. (1997). *Report of the working group advising on the quality and safety issues associated with extending limited prescribing rights to registered nurses: Report to the Director-General of Health*. Wellington: Author.

“to recommend strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders”.⁶²⁰

And on May 12, 1998 (International Nurses Day), the Minister announced that he would be introducing legislation to enable the extension of prescribing rights to nurses and other health professionals. Two areas of nursing practice had been selected for policy work for the introduction of limited nurse-prescribing. These were child family health and aged care.⁶²¹

Nurses were surprised at the initial focus on these two areas of practice. Each was potentially more complex than many other practice areas. Prescribing in the aged population was concerning because of subtle alterations in physiology, the incidence of chronic diseases in many elderly persons, and concomitant poly-pharmacy. Children too, present with physiology more complex than adults.

Judy Kilpatrick, then Chair of Nursing Council observed “If we had something to do with it I don’t think we would have said child health, elder care...we would have said something like sexual and reproductive health, and palliative care...”⁶²² Dr. Jenny Carryer, then a member of the Taskforce commented, “We kept saying that it was sexual health and public health, and palliative care and those areas that needed prescribing in terms of improving access. But it came out as child health and aged care.”⁶²³

From the perspective of the Ministry of Health, it was Frances Hughes’ experience that “Basically when the decision was made, there were...suggestions about scopes.

⁶²⁰ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington. Ministry of Health, 8.

⁶²¹ Letter to NETS on nurse-prescribing from Peter Cole, Manager, Consumer Protection, Ministry of Health, 16 June 1998. Personal papers.

⁶²² Interview with J. Kilpatrick 15 July 2002.

⁶²³ Interview with J. Carryer 22 July 2002.

We were making suggestions from the Ministry to the Government, because Council had not dealt with nurse-prescribing. It literally was the Minister's choice."⁶²⁴

Furthermore, in the mid-to late 1990s, the body of nursing was comprised of the greatest variation in educational backgrounds since perhaps the 1890s, when "nurses" included untrained men and women, nurses-in-training, and trained nurses. One hundred years later, the bachelor's degree in nursing had become more widely available to registered nurses within the last few years, and the degree, as the requirement for entry to practice, had only recently been instituted. Therefore, in 1999, only 18-19 percent of the total number of registered nurses held a bachelor's degree or higher in nursing.⁶²⁵ Approximately 60 percent of all nurses had gained their initial nursing education and registration via hospital-based training, 31 percent through a polytechnic diploma programme, and 7-8 percent through attaining a bachelor's degree.⁶²⁶ The educational experiences of each nurse inevitably contributed to her/his view of the potential of nursing roles and contributions, and the pathways to realizing that potential.

Dr. Denise Dignam, member of the Ministry of Health's working group on quality and safety issues, and later a member of the New Prescribers Advisory Committee, noted that as a nursing academic she had not been particularly informed about nurse-prescribing until she became involved in developing a more clinically-focused masters degree. Following her search of the literature and curriculum work, she was asked by the College of Nurses, Aotearoa/New Zealand to assist in the preparation of a submission to the Ministry. She observed that "One of the things that became obvious early on with that whole prescribing drive was that it was going to force the profession into making some moves about how to sort advanced practice roles".⁶²⁷

⁶²⁴ Interview with F. Hughes 22 October 2002.

⁶²⁵ Nursing Council of New Zealand. (2000b). *New Zealand registered nurses, midwives and enrolled nurses: Workforce statistics 1998*. Wellington: Author, 8.

⁶²⁶ Nursing Council of New Zealand. (2000a). *New Zealand registered nurses, midwives and enrolled nurses: Survey of educational qualifications*. Wellington: Author, 7. The figures above were derived from the Nursing Council data which included enrolled nurses in the total number of nurses and 552 nurses who did not report their educational qualification.

⁶²⁷ Interview with D. Dignam 30 October 2002.

Following the Minister's announcement, it became evident that in spite of the discussion and consultation regarding nurse-prescribing in the early 1990s, the profession was still characterised by multiple discourses relating to prescribing. Given the wide-ranging changes of the late 1980s and early 1990s, and the overall educational level of nurses; the long-standing difficulties of accessing higher nursing education; and a cultural vein in nursing which down-played the value of education for practice it is not surprising that among the discourses were ones of cynicism, apathy, and cautious or limited interest. Some held concerns that nurse-prescribing was a sly move by policy-makers to institute "cheap doctoring", or at the very least, it was a practice which would "taint" the essence of nursing.⁶²⁸ Other nurses saw nurse-prescribing as advantageous to patients, but could not see themselves expanding their practice in this way.

The thing that was also very interesting is that I don't think nursing really drove this. The reason I don't think they did, is when you ask nurses if they thought this would be useful, yes, they did see that it would be useful, but very few of them saw that they would want to do it...Even in the same field. It was not that the field didn't warrant it, but that "not me."⁶²⁹

Additionally, the complexity of extending limited or circumscribed prescribing rights was probably not well understood by nurses. Professor Shaw's discussion paper noted,

One of the difficulties is in defining just who nurses are and what they do....In 1990, there were 28,040 registered nurses in the health workforce...On graduation, a registered nurse can pursue a variety of career routes. A great majority will seek a hospital based appointment, at least initially, but there are many other options with a growing base of community based care. Examples

⁶²⁸ Making us cheap doctors. (1992). *New Zealand Nursing Journal*, July, 22.
Stodart, K. (1992). Should nurses prescribe? *New Zealand Nursing Journal*, July, 20-22.
Beekman, E. & Patterson, L. (2003). Nurse prescribing in New Zealand: Professional gain or political loss? *Nursing Praxis in New Zealand*, 19(1), 15-22.

⁶²⁹ Interview with D. Dignam 30 October 2002.

of areas of specialization include occupational health nurses, Plunket nurses, practice nurses, district nurses, psychiatric nurses, independent nurse practitioners, specialist nurses in asthma, diabetes, terminal care, continence and so on.⁶³⁰

In all submissions, the range of prescribable items requested by nurses was small and directly related to their scope of practice....While this approach is sensible, it does provide some major administrative difficulties. Because the range and scope of nursing practice is so varied, each individual group of nurses will have different requirements. The provision of 30 or 40 separate “nurse formularies” is neither logical nor desirable.⁶³¹

Although there had been consultation and discussion documents on nurse prescribing prior to the Minister’s announcement,⁶³² the possibility of prescribing was just one issue among many nurses were grappling with in the mid-1990s. Furthermore two contrasting models of education for prescribing, and contexts of prescribing practice predominated discussions: the recent extension of limited prescribing to nurses in the UK,⁶³³ and the more established Nurse Practitioner/prescriber in the United States.⁶³⁴

⁶³⁰ Shaw, J. (1994). *Prescribing rights in New Zealand: A public discussion paper*. Wellington: Ministry of Health, p.53.: An example of the continued vision of prescribing based on very limited scopes of practice can be seen in Clendon,J. (1997). Should public health nurses prescribe? *Kai Tiaki*, August, 13-15.

⁶³¹ Shaw, 1994, 56.

⁶³² Shaw, 1994.
News and events. (1997). Nurse prescribing on agenda again. *Kai Tiaki Nursing New Zealand*, March, 5.
Prescribing rights need full debate. (1994/95) *Kai Tiaki Nursing New Zealand*. Dec/Jan, 10.
Ministry of Health, 1997.

⁶³³ Clendon, J. (1997). Should public health nurses prescribe? *Kai Tiaki Nursing New Zealand*, August, 13-15.
Gunn, D. (1997). What’s in the way of nurse prescribing? *Kai Tiaki Nursing New Zealand*, May, 12.

⁶³⁴ Nursing Council of New Zealand. National consultation workshop on competence for nurse-prescribing – 8 December 1998- Draft competencies for advanced nursing practice and nurse-prescribing. (Personal papers).

NZNO's submission to Professor Shaw's discussion paper noted that "education for prescribing rights should be at post-graduate level."⁶³⁵ However, this was not a widely accepted view in New Zealand at the time. Arguments were put forth for every registered nurse to have limited prescribing, and for this to be extended further depending on scope of practice and some further short courses. Helen MacKenzie, a manager of a primary health service, and NZNA President (1990-1994) welcomed the Minister's announcement. She predicted,

A number of providers may run their own, in-house training courses for nurses who have already completed the necessary general competencies. Some educators have said nurse prescribing papers will have to be delivered at a Masters level. I would rather see these papers incorporated into a Bachelor's degree and be available to a currently practicing, registered nurse who is competent in her particular area. We need to remember we are wanting to expand nurses' clinical practice, not turn them into pharmacologists.⁶³⁶

On the other hand, Professor Shaw's paper had pointed out that

If education for prescribing is tackled in a fragmented way, then prescribing decisions may be made without a clear understanding of the full implications of such decisions. There must be a broad and full knowledge base for the formulation of professional decisions. Competency-based education makes assumptions about an agreed level of competence and is essentially task-oriented. It is debatable whether prescribing practice can be circumscribed in this way.⁶³⁷

Some nurses made a case for prescribing across a much wider context.

⁶³⁵ Prescribing rights need full debate, 1994/95, 10.

⁶³⁶ Manchester, A. (1998). Nurses gain right to prescribe. *Kai Tiaki: Nursing New Zealand*, June, 12.

⁶³⁷ Shaw, 1994, 23.

I argued that we should alter the undergraduate preparation sufficiently so that all new graduates came out with the ability to prescribe low-level across the counter medications and some other items; and then that the more advanced levels of prescribing were related to scopes—That it was ridiculous to have nurses working in hospitals who had to ask permission to give somebody panadol, and yet they could monitor CVP lines and give intravenous God knows what!...But for some reason it didn't seem possible.⁶³⁸

Frances Hughes' observation suggests the political realities for extending prescribing:

When we were getting the two scopes up...I had people ringing up and saying, "That's not the way to go. We should go the way of the midwives."⁶³⁹ I thought, it's nothing like the midwives. We have 33,000 registered nurses. We will lose the war.⁶⁴⁰

The "war" was the inevitable conflict with the medical profession. While the Minister had been advocating "nurse-prescribing, extended roles...shifting of professional boundaries",⁶⁴¹ these moves would not be widely embraced by physicians. In a two-page editorial, Anton Wiles, Chairman of the New Zealand Medical Association, created the spectre of patient endangerment due to nurse-prescribing.⁶⁴² Using unattributed anecdote and quotes, he drew a spectre of a nurse-prescriber who saw prescribing in child health and aged care as "easy"; who practiced from intuition and

⁶³⁸ Interview with J. Carryer 22 July 2002.

⁶³⁹ Registered midwives had been granted prescribing rights in the Nurses Amendment Act 1990. However, as noted in the Shaw paper, while midwives have an "unlimited list" of drugs, they prescribe only within their scope of practice; that is prenatal, intrapartum, and postnatal care. Furthermore, midwives constitute a small group, estimated at 2030 active midwives in 1999. [Nursing Council of New Zealand. (2000). *New Zealand registered nurses, midwives and enrolled nurses: Survey of educational qualifications*. Wellington: Author, 16.]

⁶⁴⁰ Interview with F. Hughes 22 October 2002.

⁶⁴¹ Minister outlines opportunities for nurses. (1997). *Kai Tiaki: Nursing New Zealand*, Oct, 13.

⁶⁴² Wiles, A. (1998a). Who will determine prescribing competence? *New Zealand Medical Association Newsletter*, 12 June, 1, 4.

“magic”; and who would consider s/he was as competent as a doctor by attending a “Saturday course”.⁶⁴³

His particular concern, however, was that doctors would not be determining what, when and how nurses would be able to prescribe. Riled by a statement attributed to Nurse Executives of New Zealand that nursing practice “must not be limited with restricted freedom within pre-prescribed parameters dictated by the medical profession”,⁶⁴⁴ he also directed his enmity at the Minister of Health and “a senior employee of the Ministry (a former nurse)”.⁶⁴⁵ As John Shaw noted, there would be “turf battles”, and the “knee-jerk response will be ‘Over our dead bodies’”.⁶⁴⁶

Frances Hughes’ experience as the Chief Nursing Adviser in the Ministry echoed this. “There was a lot of furore from the medics....There was a lot of hostility about it, and it went right through even to the Select Committee in 1999.”⁶⁴⁷ Inevitably the Ministry of Health would be heavily involved in developing recommendations for policy and legal changes. However, for the regulatory mechanisms for the practitioner with expanded rights and responsibilities, the Ministry would look for dialogue with the health profession’s statutory body, which in turn, would look to its consultation with the public and the profession. But the Nursing Council did not yet have a framework.

We literally had to describe it from the center, when we had no real indication from the profession of what it would look like. We were basically modeling on what was the best out of international components....The whole concept of nurse-prescribing was as a tool, as a part of advanced practice. So that meant it legitimized us working on the things around advanced practice....And we realized then that the Nursing Council had nothing on this. Part of the reason

⁶⁴³ Wiles, 1998a, 1.

⁶⁴⁴ Wiles, 1998a, 4.

⁶⁴⁵ Wiles, 1998a, 4.

⁶⁴⁶ MacLennan, C. (2000). Prescribing the limits. *New Zealand Education Review*, 5(8), 10.

⁶⁴⁷ Interview with F. Hughes 22 October 2002.

why we ended up with such prescriptive regulations for the first two scopes was that...there was nothing in the Nursing Council framework – they hadn't done any work or thinking around competencies, or anything else around advanced nursing. So they were prescriptive because they didn't have anything we could take to government that they could manage it.⁶⁴⁸

Nursing Council's consultation on competencies for nurse-prescribing did not commence until December 1998.⁶⁴⁹ In spite of the Ministry of Health's dialogue and national consultation regarding extension of prescribing rights in 1994, Nursing Council's Strategic Plan for the period April 1994-March 1997 makes no mention of competencies for, or a potential role for Council in relation to nurse-prescribing. The only strategic issues noted which related to post-registration matters were 1) the development of competency-based annual practicing certificates, and 2) the opportunity to develop post-registration specialist competencies. The latter is mentioned as a "less urgent non-prioritised critical strategic issue".⁶⁵⁰

Council revised this plan in 1995, listing "opportunity to develop post-registration specialist standards and competencies" as one of seven co-equal issues.⁶⁵¹ The 1995 revised plan only refers to specialist, and does not make reference to advanced, nor is there use of a broader term. The Council's work on standards for post-registration nursing education arose from the impetus for approval by Council of CTA-funded programmes – spurred by Frances Hughes' policy entrepreneurship. Other policy entrepreneurs were coming to the fore in the mid-to-late 1990s.

⁶⁴⁸ Interview with F. Hughes 22 October 2002.

⁶⁴⁹ Personal papers. Nursing Council National consultation workshop on competence for nurse-prescribing – 8 December 1998.

⁶⁵⁰ *Nursing Council of New Zealand strategic plan: 1 April 1994-31 March 1997*. Wellington: Author, 7, 15.

⁶⁵¹ *Nursing Council of New Zealand strategic plan: 1 April 1997-31 March 2000*. Wellington: Author, 9.

Judy Kilpatrick became a member of the Nursing Council in 1996, and was elected Chairperson at the first meeting she attended in May of that year.⁶⁵² Kilpatrick reflected on her approach as Chair:

I had been Head of School – the largest school in New Zealand. I was fairly confident about chairing or leading, I suppose... I certainly knew that coming from an education background was in fact an advantage....⁶⁵³

When I say I'm a bit operational it's because I like to make the policies happen....I see it all linked. How it happens is the strength of the policy.⁶⁵⁴

During that year, Nursing Council “convened a group of specialist nurses and nurse educators with a national overview” to begin work on developing standards for post-registration nursing education.⁶⁵⁵ By December, the Council had invited submissions on the first draft for Standards for Post-Registration Nursing Courses, which had differentiated specialist and advanced nursing practice.⁶⁵⁶

In February 1997 Frances Hughes, newly appointed as senior nursing advisor in the Ministry of Health, became the Ministry's representative on Council, replacing the then Chief Nursing Advisor, Gillian Grew.⁶⁵⁷ The Council's 1997-2000 strategic plan does identify the implementation of post-registration standards and competencies as one of its strategic issues. The rationale given is that “a framework and approval process is required for post-registration nursing courses designed to prepare registered nurses for specialist or advanced nursing practice.”⁶⁵⁸

⁶⁵² Wood, P.J. & Papps, E. (2001). *Safety to practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*. Wellington: Nursing Council of New Zealand, 105.

⁶⁵³ Wood & Papps, 107.

⁶⁵⁴ Wood & Papps, 109.

⁶⁵⁵ Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author, 3.

⁶⁵⁶ Nursing Council of New Zealand. (1998). *Framework, guidelines and competencies for post-registration nursing education*. Wellington: Author, 3.

⁶⁵⁷ News and events. (1997). New faces on Council. *Kai Tiaki Nursing New Zealand*, March, 10.

⁶⁵⁸ *Nursing Council of New Zealand strategic plan: 1 April 1997-31 March 2000*. Wellington: Author, 15, 22.

However, the use of the terminology “advanced nursing programme” created some confusion as the whole scenario of CTA-funding and nurse-prescribing evolved. In an interview with Judy Kilpatrick, I asked her about this, noting

...and then we had this anomaly of things being approved as advanced programmes that were PG Certs.(postgraduate certificates) or PG Dips. And with that, no one was quite sure about an advanced programme—things were happening so quickly.

I think so. I think you have to be aware of what’s happening at the time. If you held it ...that you were only applying “advanced” as an end to a master’s output, which in the purest sense you should,...so your top level person meets those. Now whether you in a structure, have a postgrad exit as a diploma- so be it.

What did you have? Two or three schools putting up masters. It just wiped out other providers who were not going to get to masters at all. ...and it would seem to me that a number of people have done postgrad certs. And dips well....In time, with preference, your purist would say it should have been overall within the masters, but in fact, what we tried to do was say, any study, at that level, because study was just one arm. You see how that person went and applied it in practice and what they did made them the nurse practitioner.⁶⁵⁹

The Ministerial Taskforce was established in February 1998 before Council had finalized its Framework. The Taskforce presented its report in July, with the Minister having announced the intention to enable nurse-prescribing in May. The Ministry of Health, Nursing Council and nursing professional groups were impelled into action.

⁶⁵⁹ Interview with J. Kilpatrick 15 July 2002.

Proposals to advance nursing practice

In the health sector milieu of the 1990s, the need to expand, extend, and advance nursing practice was evident to many inside and outside the profession, and the opportunities for post-registration education presented pathways to developing requisite knowledge and skills. Successive reports to Government pointed out, albeit in small print, the potential to improve access and efficiencies by permitting nurses to prescribe medicines and other treatments.⁶⁶⁰ The underpinnings of this expansion of practice were not yet entirely clear.

Alongside the development of Nursing Council's *Framework*, leaders in professional nursing organizations were also developing proposals. Nurse Executives of New Zealand (NENZ) were working on a proposal for the development of an advanced nursing practitioner. In January 1998, a meeting to collaborate on the role and preparation for a nurse practitioner in New Zealand was held with representatives of NENZ, NZNO, NETS, CNA,(NZ), and the Nursing Council.⁶⁶¹

Notes of the meeting indicate discussion of the differing needs for such a practitioner. For example, the requirements for the nurse practitioner in rural areas differed from that in large hospital settings, where "the need is for a nurse able to work across a range of specialties and to undertake a number of tasks now done by junior doctors".⁶⁶² A brief summary of scope of practice for an acute care nurse practitioner was seen as "across the health-illness continuum; independent practice in a collaborative health care team; skills of assessment, diagnosis, care management, evaluation and patient outcome; admitting and discharge rights".⁶⁶³

⁶⁶⁰ Shaw, 1994.
Ministry of Health. (1996). *Healthy New Zealanders: Briefing papers for the Minister of Health 1996*. Wellington: Author, 44.
CAPE. (1997a). *Towards a strategy for the education and training for the health and disability support sector: A discussion document*. Wellington: Committee Advising on Professional Education, 11.

⁶⁶¹ NETS communication: Report of meeting with Nurse Executives re: Nurse practitioner role, 30 Jan 1998. Personal papers.

⁶⁶² NETS communication: Report of meeting with Nurse Executives re: Nurse practitioner role, 30 Jan 1998. Personal papers.

⁶⁶³ NETS communication: Report of meeting with Nurse Executives re: Nurse practitioner role, 30 Jan 1998. Personal papers.

While preparation for this role was considered to be both academic and clinical, and “linked to masters level education”, the NZNO President, Judi Mulholland “disagreed, indicating that this would exclude a number of nurses working at that level in practice.”⁶⁶⁴ This NZNO position would be sustained over the next several years. NENZ further developed and published their proposal, *Developing and supporting advanced practice roles: Clinical nurse specialist, nurse practitioner* in April, 1998.⁶⁶⁵

Concurrently in that 1997 period, the CNA,(NZ) were also developing a proposal for a “national education strategy which supports nurses able to deliver flexible, responsive patient focused services”.⁶⁶⁶ In addition to giving priority to passage of a new Nurses and Midwives Act, this proposal also recommended the “formation of a Ministerial taskforce to recommend to the Minister of Health the actions required by Government to support the evolving role of nurses”.⁶⁶⁷ A Ministerial Taskforce was established in February 1998 “in response to a consensus proposal from nursing leadership and nursing organizations”.⁶⁶⁸

Ministerial Taskforce on Nursing

In launching the Taskforce, the Minister noted,

⁶⁶⁴ NETS communication: Report of meeting with Nurse Executives re: Nurse practitioner role, 30 Jan 1998. Personal papers.

⁶⁶⁵ Nurse Executives of New Zealand. (1998). *Developing and supporting advanced practice roles: Clinical nurse specialist, nurse practitioner*. Auckland: Author. [It is noted (p.10) that the proposal was developed by Jocelyn Peach, Beth Cooper-Liversedge, Lyneta Russell, and Gay Hayes.]

⁶⁶⁶ NETS communication sent 9 March 1998: Proposal from College of Nurses, Aotearoa, Re: A national education strategy which supports nurses able to deliver flexible, responsive patient focused services. (Not dated). Personal papers.

⁶⁶⁷ NETS communication sent 9 March 1998: Proposal from College of Nurses, Aotearoa, Re: A national education strategy which supports nurses able to deliver flexible, responsive patient focused services. (Not dated). Personal papers.

⁶⁶⁸ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 8.

nurses were concerned about historical, prescriptive rules and regulations around how nurses worked and other barriers which prevented them from fulfilling their potential...The profession sought my support to establish such a taskforce and I was, in fact, thinking along fairly similar lines.⁶⁶⁹

Media briefing papers on the Taskforce echoed the CNA,(NZ) call for strategies to enable nurses to deliver care in “the most patient-focused and efficient way.”⁶⁷⁰

Jenny Carryer, Executive Director of the CNA,(NZ), and member of the Taskforce,⁶⁷¹ spoke of some of the people who were instrumental in supporting her call for a Taskforce: “Judy Kilpatrick; Joc Peach in Nurse Execs; and Ali (Dixon) come to mind.”⁶⁷² Carryer recalled how she went to see the Minister of Health, Bill English, in November 1997.

I ...said we needed a taskforce. I drew up a sort of whole case around the major barriers that were impeding the development of nursing, and pointed out—showed him how they were interlocked, and they were high level. And that to actually resolve them we needed to understand them better and have a kind of strategic plan and that I would like to bring together all the nursing organizations and a funded Ministerial taskforce.

And he agreed.

⁶⁶⁹ O’Connor, T. (1998). Nursing taskforce formed. *Kai Tiaki: Nursing New Zealand*, March, 10.

⁶⁷⁰ O’Connor, 1998, 10.

⁶⁷¹ Members of the Taskforce: The Hon. Dame Ann Hercus (Chairperson from 23 February to 30 June 1998); Toni Ashton, Health Economist, University of Auckland (Chairperson from 1 July to 21 July 1998); Dr Jenny Carryer, Nursing Lecturer, Massey University and Executive Director, CNA(NZ); Beth Cooper-Liversedge, Clinical Director, Nursing and Professional Practice, Good Health Wanganui, Nurse Executives of New Zealand; Frances Hughes, Chief Nursing Officer, Ministry of Health; Judy Kilpatrick, Head of School, Nursing and Midwifery, Auckland Institute of Technology, Chairperson, Nursing Council of New Zealand; Julie Martin, Manager, Nursing Services, Health Funding authority, North Office; Brenda Wilson, CEO, NZNO; Denise Wilson, Nurse consultant, Lakeland Health, Ngati Tahinga.

⁶⁷² Interview with J. Carryer 22 July 2002.

Very quickly. And it was announced in early 1998.....and my sense in talking with him was that he had had exposure in various settings which had led him to believe that what I was talking about made sense. I think it fell on fertile ground. I think he as Minister of Health was frustrated by the sort of recycled nature of the problems in delivering health care, and I think he thought that resourcing and spending some energy on nursing would pay dividends.⁶⁷³

Indeed, as early as 1991, the previous Minister of Health, Simon Upton had explicitly signaled the National government's view that barriers needed to be removed to enable nurses to effectively deliver services, that there was support for nursing to expand its jurisdiction, and that there was support for nurses to reclaim more of primary care.⁶⁷⁴ In a lengthy editorial in *Kai Tiaki* Upton noted,

Nurses are key players in the health system, but over the years have struggled to overcome being perceived and treated as “handmaidens” to doctors.....The reforms announced in July will, I hope, open the way to many more opportunities and innovative approaches across the health system. And I think nurses should be looking carefully at these opportunities....Primary care is an area which I believe deserves far more attention....there should also be more options for nurses working in the community. I realize there are legislative barriers to nurses carrying out some procedures, and this is something I am looking at – with your input....In some countries nurses see and examine patients, make diagnoses and referrals and write prescriptions alongside doctors. Nurses bring a unique focus which is complementary to the medical model.⁶⁷⁵

However, in 1991, nursing was certainly not positioned to make immediate use of such suggestions.

⁶⁷³ Interview with J. Carryer 22 July 2002.

⁶⁷⁴ Upton, S. (1991/1992). Golden opportunities? *New Zealand Nursing Journal*, Dec/Jan, 2-3.

⁶⁷⁵ Upton, 1991/1992, 2.

Following its formal announcement of February 23, 1998 the Taskforce conducted extensive consultation, receiving individual and group submissions; consulted with agencies in the health and disability sector and with other key stakeholder agencies; carried out a number of consultative gatherings with Maori; and conducted a series of ten focus group meetings throughout New Zealand.⁶⁷⁶ Its reporting date was extended from 30 June to 21 July.

In May, when the Taskforce was in the middle of its processes, the Minister announced the government's intention to extend prescribing rights to nurses. Jenny Carryer's recollection was that she did not "believe that in making a case I'd focused on nurse-prescribing particularly....."

I mean, it wasn't really even about nurse practitioners and prescribing, although we knew—I always felt we had to get the ground right first....In my head, and I know in Frances' head, we had a long-term vision of developing nurse practitioner roles, etc, but we knew that there was a big hole in the profession as a result of the '90s that had to be sorted out first.⁶⁷⁷

However, the Minister's announcement could not be considered a surprise, since extension of prescribing rights to nurses had been explored since 1992. In January the Minister had appointed a working group "to advise the Director-General of Health on the safety, education and other relevant issues which would need to be resolved before limited prescribing rights could be extended to nurses".⁶⁷⁸ The report of the working group had been published in November. Clearly, the Minister was adding impetus and weight to what would be the Taskforce's eventual recommendations.

Judy Kilpatrick, Chair of Nursing Council at that time, and member of the Taskforce noted that "the Taskforce was constantly saying, -a lot of it is about prescribing.

⁶⁷⁶ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 9-11.

⁶⁷⁷ Interview with J. Carryer 22 July 2002.

⁶⁷⁸ Ministry of Health. (1997). *Report of the working group advising on the quality and safety issues associated with extending limited prescribing rights to registered nurses: Report to Director-General of Health*. Wellington: Author, 1.

That's why the terms of reference were "what are the barriers? What are the strategies? But he did race ahead and decide to do it now."⁶⁷⁹ And the Taskforce "straight away said, 'we support this'. It didn't even wait until the end, it straight away said we support this."⁶⁸⁰

However, other issues were the initial concern of some taskforce members.

...The difficulty of transferring graduates into the community, the absolute inappropriateness of having the bulk of nurses in the community employed by GPs,-- whose notion of practice was constrained. And I talked a lot about our...challenges around transitioning graduates into practice. And the need for funding that first year....It was about the lack of nurse leadership in the community. It was about responding to the destruction of nursing leadership through the 1990s through the health reforms.⁶⁸¹

The report of the Taskforce outlined thirty-seven recommendations, each directed to one or more organizations, agencies, Ministries or statutory bodies. It addressed issues relating to the need for the expansion of the scope of nursing practice; funding for the services of advanced nursing practitioners; barriers to funding of post-registration and postgraduate nursing education; support for nursing research at the national level; the loss of nursing voice in senior level health management and policy arenas; broad workforce issues; and concerns of particular import to Maori. But what captured attention at the time was the hostile withdrawal of NZNO from the process.

NZNO and advanced nursing practice

Unfortunately, in spite of considerable effort and weeks of discussion, we were unable to find consensus with the New Zealand Nurses' Organisation (NZNO). The NZNO has been part of the Taskforce for the last five months and hence was privy to all negotiations and documentation from the outset.

⁶⁷⁹ Interview with J. Kilpatrick 15 July 2002.

⁶⁸⁰ Interview with F. Hughes 22 October 2002.

⁶⁸¹ Interview with J. Carryer 22 July 2002.

Many changes were made to drafts of this report to accommodate the concerns of NZNO. The outstanding issues, as far as we can determine, relate primarily to the status and role of NZNO rather than to the Taskforce's terms of reference or to patient outcomes.....It is with regret that we must present this report without the support of NZNO.⁶⁸²

These comments from the two Chairs of the Taskforce in the preface to the *Report of the Ministerial Taskforce on Nursing* underscore the fracture within the profession. *Kai Tiaki's* August 1998 editorial, written by NZNO Chief Executive, and member of the Taskforce, Brenda Wilson, presented a number of reasons for NZNO's withdrawal from the Taskforce, beginning with her claim that the report of the Taskforce was not representative of the profession.

We are this country's largest professional nursing organization. We represent the professional and employment aspirations of 22,000 nurses. No other taskforce representative can claim that mandate.⁶⁸³

Implicit in this statement is the view of the NZNO executive that members of the Taskforce were selected to represent their organizations' perspective in particular, rather than to bring their broad nursing leadership to the process. According to the Chairs of the Taskforce, (Hon. Dame Ann Hercus, Chair 23 February-30 June 1998 and Toni Ashton, Chair, 1-21 July 1998), the NZNO executive was fully aware of the representation and process from the outset, and throughout five of the five and one-half months the Taskforce sat.⁶⁸⁴

Wilson's *Kai Tiaki* editorial goes on to discuss four key reasons for NZNO's withdrawal, however closer scrutiny suggests obfuscation of the issues on the one hand, and a revelation of the issues central to NZNO's deep sensitivity on the other.

⁶⁸² Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 5.

⁶⁸³ Wilson, B. (1998). NZNO and the Taskforce. *Kai Tiaki: Nursing New Zealand* 4,(7), 2.

⁶⁸⁴ Ministerial Taskforce on Nursing, 1998, 5.

Wilson's first claim against the Taskforce report was that it did not reflect the views of NZNO's members. She also claimed that Taskforce members were never told the exact number of submissions received which were summarised by the Taskforce secretariat. However, the Taskforce Report does indicate that 1137 submissions were received, plus another ten after the closing date.⁶⁸⁵ Wilson cites the following as concerns noted in the secretariat's summary which,

echoed many of the concerns raised in NZNO's submission to the taskforce: concerns about patient safety and skill mix; about terms and conditions of employment; about access to post-registration education; about development of nursing leadership; about how legislation restricts the ability of nurses to function more effectively; about the funding and contracting system for health and disability services and what this means to the work of the profession. However these are not central to the taskforce report.⁶⁸⁶

Yet all of these issues are addressed in the Taskforce Report. Patient safety and workforce skill-mix matters are key features of the Report's chapter on Workforce Resourcing. Clinical career pathways, pay and conditions and a range of related employment matters are also addressed in this chapter. Education, including post-registration education, nursing leadership, and funding matters are each the subject of individual chapters in the report. Legislative barriers underpin several of these chapters.

Wilson's editorial also noted that during the sitting of the Taskforce, legislative changes were passed which eliminated NZNO's exclusive right to nominate nurses to Minister of Health for appointment to the Nursing Council.⁶⁸⁷ However, these changes were not unexpected, and the removal of Ministerial staff from statutory

⁶⁸⁵ Ministerial Taskforce on Nursing, 1998, 91.

⁶⁸⁶ Wilson, 1998, 2.

⁶⁸⁷ The Health Occupational Registrations Act Amendment Act 1998, changed the representation on health registration boards, including the Nursing Council. Changes to Nursing Council membership included the removal of the Ministry of Health representative, the Chief Nursing Advisor; elimination of the medical representative; and removal of the New Zealand Nurses' Organisation's sole right to nominate nursing representatives to the Governor-General for appointment.

councils, and permitting nominations to the councils from the wider profession, were changes designed to reduce political bias on such councils.

The third reason Wilson cited for NZNO's withdrawal from the Taskforce related to the Taskforce's recommendations regarding the Nursing Council.

To fulfill many of its recommendations the taskforce relies on legislative change to expand the role of Nursing Council. NZNO has major difficulties with this expanded role.....The taskforce recommendations also mean the council will develop, control and enforce competencies for advanced and specialist practice. NZNO does not believe the council is the appropriate body to direct advanced and specialist practice. The council's role is to regulate the profession in the interests of public safety. It is inappropriate to concentrate the direction of professional practice in a very few, politically-appointed hands.⁶⁸⁸

The Taskforce report had recommended that the Nursing Council "work with nursing organisations, agencies in the health and disability services sector, and postgraduate education providers to develop, recognise and validate specialist competencies, within a larger framework, which are linked to nationally consistent titles,"⁶⁸⁹ and that the Ministry of Health "urgently address the current limitations of the Nurses Act 1977 which prevent the Nursing Council enforcing competency-based practising certificates and specialist and advanced competencies for practitioners."⁶⁹⁰ The notion that the Nursing Council should validate specialist competencies was not a new concept. Following the Medical Practitioners Act 1995, the Ministry of Health undertook a comprehensive review of eleven occupational regulation acts which came under its administration. In its "draft reports for discussion"⁶⁹¹ it was noted,

⁶⁸⁸ Wilson, 1998, 2.

⁶⁸⁹ Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health, 18.

⁶⁹⁰ Ministerial Taskforce on Nursing. 1998, 15.

⁶⁹¹ Ministry of Health. (1997). *Reform of health sector occupational regulation statutes: Draft reports for discussion*. Wellington: Author.

In the Ministry's view, it is desirable that the Council is able to recognise specialist competencies if there are patient safety reasons for doing so...Most submissions support providing for the Council to both endorse advanced qualifications, and to be able to designate specialist registration areas in the Act if there are consumer safety reasons for doing so.⁶⁹²

Also related to this, NZNO was concerned to ensure that its current members were not threatened by requirements for advanced education.

The taskforce expects nurses to complete masters-level education to move into advanced and specialist roles. This means a nurse with ten years' clinical experience in a practice specialty, who may be accredited by the relevant section, may not be recognised as an advanced practitioner. NZNO wants a more inclusive framework for advanced practice which allows recognition of the many ways nurses can develop clinical excellence. The cost of masters-level education is prohibitive for many nurses.⁶⁹³

Gay Williams, a long-serving NZNO member, and President from 1987-1994, observed that

Many nurses prepared in the hospital apprentice system are still in practice, with a large number without any educational qualifications post registration...This can result in a cohort of nurses without the attitudes and beliefs to actively respond to the context or to move forward....while education has always led the way...the changes are very recent...We need to remember that advanced preparation for the nurse was essential to enable the profession to move forward...⁶⁹⁴

⁶⁹² Ministry of Health, 1997, 6.

⁶⁹³ Wilson, 1998, 2.

⁶⁹⁴ Williams, 2000, 112.

In her editorial, Wilson drew a picture of the future bounded by the limitations of the past. NZNO's executive also ignored the organisation's 1991 document on clinical practice development, and its earlier wisdom on the complementary value of experience, education, complexity of practice role and setting, and clinical leadership.⁶⁹⁵

At the heart of the issue, NZNO's executive was incensed that it was not given the mandate to control the credentialing process. It was déjà vu from the early days of the separation of the Division of Nursing, the Council and NZNA. As Shirley Bohm's reflections on the difficulties of the loss of insider-association for NZNA following the Nurses Act 1971, discussed in Chapter 7 - "and they would ask to do something crazy like take over the Nursing Council".⁶⁹⁶

While NZNO acknowledged the role of the Nursing Council to ensure the safety of the public with regard to nursing practice, it seemed blind to the fact that the Council was the only neutral and legitimate body to carry out credentialing of advanced nurse practitioners. The New Zealand Medical Association seized the opportunity created by a profession divided to wade in alongside NZNO, in an attempt to discredit the Taskforce report.⁶⁹⁷

NZNO's response to the Taskforce report, *Building partnerships: Developing the future of nursing* was released later in 1998.⁶⁹⁸ In the opening statement, the President of NZNO, Judi Mulholland expressed her pride "in the stand which NZNO has taken over the Ministerial Taskforce on Nursing."⁶⁹⁹ The key premise of the document was that "true professions take responsibility for regulating themselves."⁷⁰⁰

⁶⁹⁵ New Zealand Nurses' Association. (1991). *A Proposal for Career Development for Nurses in Clinical Practice*. Wellington: Author.

⁶⁹⁶ Interview with S. Bohm, 25 March 2000.

⁶⁹⁷ Wiles, A. (1998b). Two professions share misgivings. *New Zealand Medical Association Newsletter*, 11 September, 1-2.

⁶⁹⁸ New Zealand Nurses Organisation. (1998). *Building partnerships: Developing the future of nursing*. Wellington: Author.

⁶⁹⁹ NZNO, 1998, 2.

⁷⁰⁰ NZNO, 1998, 6.

However, it renounced the Nursing Council as an arm of the profession when it purported that “The Taskforce refused to embrace self-regulation and supported Nursing Council having powers to define and enforce competencies for advanced and specialty practice”.⁷⁰¹

Out of the thirty-seven wide-ranging recommendations in the *Report of the Ministerial Taskforce*, only the two cited above related specifically to advanced and specialty practice competencies. But these two recommendations undermined what NZNO saw as its mandate.⁷⁰²

While NZNO’s response to the Taskforce report espoused partnerships, other than one reference to NENZ, it did not mention partnerships with other nursing organisations such as NETS, ANZCMHN or CNA(NZ). It made no mention whatsoever of liaison with the Ministry of Health’s Chief Nurse. Indeed, it would seem that for most of the 1990s, NZNO had very tense and occasionally hostile relationships with both the Nursing Council and the Chief Nurse in the Ministry of Health.⁷⁰³

Comparing the Taskforce scenario against the response to the Project 1991:Vision 2000 recommendations, one is struck with a sense of déjà vu. In the case of Project 1991:Vision 2000, NZNO lost the opportunity to lead broad professional dialogue about pre-registration nursing education through *Kai Tiaki* and other mechanisms. In the case of the Taskforce, as New Zealand’s largest nursing organisation, NZNO squandered its power.

⁷⁰¹ NZNO, 1998, 6.

⁷⁰² Cooper-Liversedge, B. (1998). Editorial: The Ministerial Taskforce on Nursing. *Nursing Praxis in New Zealand*, 13(3), 2-3.

⁷⁰³ Interview with F. Hughes 22 October 2002.
Interview with J. Carryer 22 July 2002.
Wood, P.J. & Papps, E. (2001). *Safety to practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*. Wellington: Nursing Council of New Zealand, 88-89, 111-112.

Interestingly, both situations occurred in the volatile 1990s, and both were about educational level(s) in nursing. As Gay Williams noted, the 1990s brought unprecedented challenges to NZNO, and its responses led to

much criticism of NZNO by nurses, including its members. Such criticisms include perceived lack of leadership, a focus on industrial issues to the detriment of professional development, lack of ability to work alongside other nursing/nurses' organisations and lack of consultation on issues of importance to the profession.⁷⁰⁴

The rapidly changing health sector, together with the socio-economic challenges of the times certainly created a climate of uncertainty. However, it seems that NZNO could only focus on the dangers rather than a path of possibilities. In seeing challenges through a lens of unionism, and finding themselves in a defensive fighting stance with 'their backs to the wall', NZNO was unable to form coalitions with other health professionals, the public and other nursing organisations, and had its view of how the profession could respond to the country's unmet health needs obscured.

Additionally, NZNO was now juggling the potentially conflicting professional claims of not only enrolled nurses versus registered nurses, it had expanded its membership and representation to health sector caregivers. The union-focused concerns arising in the late 1980s and early 1990s had caused,

...a whole group of nursing leadership to opt out of it (NZNO). And so the whole support for advanced practice from a professional organisation – the only one that consistently gave support- visible support- was the College of Nurses. And they were just a pebble in the sea.⁷⁰⁵

While it had been more than twenty-five years since the separation of the triumvirate of the Nursing Council, the Division, and NZNA into "three streams of nursing power

⁷⁰⁴ Williams, 2000,138.

⁷⁰⁵ Interview with F. Hughes 22 October 2002.

and political influence”,⁷⁰⁶ rivalry and conflict, rather than coalition building predominated. Sullivan and others⁷⁰⁷ suggest that when nursing organisations are pre-occupied with self-interest, they get into a cycle of inward focus, conflict and competition. Instead of being able to see the potential for collaboration, to “advance nursing and nurses,”⁷⁰⁸ NZNO persisted in a power play over the Taskforce report.

Sue Hine, a professional advisor for NZNA/NZNO had foreshadowed this predicament.⁷⁰⁹ She argued for NZNO to be “the country’s recognised professional nursing organisation”,⁷¹⁰ and she described her perception of three stages in the 1990s during which NZNO struggled to respond to professional issues. Writing in 1997, Hine urged

NZNO must now enter stage three which may prove to be the most difficult....Getting the right structure and the right people will not fix all the problems. Providing professional leadership is not about one person or group of people providing all the answers. This can only come when the profession at large is prepared to work together to achieve a vision for nursing.⁷¹¹

Natali Allen had presaged this situation as well in the wake of the Vision 2000: Project 1991 Forum.⁷¹² She noted in her discussion paper the increase in various nursing organisations, the perception that NZNA was neglecting professional issues in favour of union concerns, and the,

⁷⁰⁶ Kinross, N. (1984 b) Politics and power. In M.G. Smith & Y.T. Shadbolt (Ed.), *Objects and outcomes: New Zealand Nurses' Association 1909-1983* (pp 94-117). Wellington: New Zealand Nurses' Association, 110.

⁷⁰⁷ Sullivan, E. (1999). Editorial: Partners in time. *Journal of Professional Nursing*, 15(2)..67-68.
Cohen, S., Mason, D., Kovner, C., Leavitt, J., Pulcini, J. & Sochalski, J. (1996). Stages of nursing's political development: Where we've been and where we ought to go. *Nursing Outlook*, 44(6), 259-266.

⁷⁰⁸ Sullivan, 1999, 68.

⁷⁰⁹ Hine, S. (1997). Promoting a professional profile. *Kai Tiaki Nursing New Zealand*, March, 11.

⁷¹⁰ Hine, 1997, 11.

⁷¹¹ Hine, 1997, 11.

⁷¹² Allen, 1992, 28-30.

potential for parallel structures, overlapping functions and conflicts between nurses over professional goals and approaches. These factors can only impede development, are recognised as doing so by many nurses, and will increasingly do so unless some clear decisions are made and individuals are prepared to respect them.⁷¹³

Struggling in the changing tide, NZNO leadership undermined the relevance of the Taskforce report, engaged in open warfare with the Nursing Council, courted the undermining favours of the medical association, and polarised the profession. It failed to capitalise on another opportunity to enhance nursing's professional project. In spite of its eighty-nine year history, in 1998, NZNO was not acting like politically sophisticated organisation.⁷¹⁴

The wounds of health reforms and the wider state sector reforms - the disestablishment of nursing leadership positions throughout the health sector; the deep sense of health sector managers devaluing of nurses' work; the impact of the ECA; the replacement of enrolled nurses with generally untrained caregivers; increasing workloads of more acutely and chronically ill patients, in and out of hospital; and remuneration packages in which shift work was the only apparent recognition – were among the many factors which contributed to responses which were at turns, cynical, defensive, aggressive, apathetic.⁷¹⁵

Not infrequently, persons “new to the scene” can bring a different perspective. Shortly after the publication of the *Report of the Ministerial Taskforce on Nursing*, Ketana Saxon, Chair of the NZNO national student unit during 1994/95, and a nurse of only two years experience, observed

⁷¹³ Allen, 1992, 29

⁷¹⁴ Cohen et al, 1996, 259.

⁷¹⁵ Letters. (1998). *Kai Tiaki: Nursing New Zealand*, October, 3-5.
Lichfield, M. (2002). Nurse practitioner role limits the profession. *Kai Tiaki: Nursing New Zealand*, September, 20.
News and events, 1998.
Williams, 2000, 330.
Wilson, 1998, 2.

In regard to the taskforce report and subsequent debate, the point I am trying to make is that no matter how motivated nurses are, no matter how visionary the ideas being contributed to practice by nurse researchers and academics, the majority of nurses still work in clinical settings where the ability to translate nursing vision into practice is severely restricted by unacceptable and unsafe working conditions...I wonder at the incongruence of a Government which, on the one hand says it welcomes a move to expand and enhance nurses' roles, which on the other, promotes a health system within which highly educated and skilled nurses are undervalued and overstressed; a health system where in many places nurses are being replaced with untrained caregivers. In such a climate, is it unreasonable to suspect that the move to encourage nurses to take on aspects of doctors' work could yet be another cost-cutting exercise? At the same time it is worrying to hear nurses at the proverbial "coalface" dismiss aspects of the taskforce recommendations, which have the potential to empower and enhance nursing roles, as the ideas of an "elitist" group.⁷¹⁶

Détente eventuated. By 2000, NZNO's position statement on advanced nursing practice stated, "Being an expert-by-experience in a specialty is not on its own sufficient for advanced nursing practice".⁷¹⁷ It went on to note the expectations of postgraduate study, and that,

NZNO supports recognition and professional self-regulation through professional associations and not through statute, the exception being the registration of independent nurse prescribers...NZNO supports a national standard being adopted by all nursing groups in New Zealand for the process of credentialing advanced nurse practitioners.⁷¹⁸

⁷¹⁶ Saxon, K. (1998). Bringing education and practice closer. *Kai Tiaki: Nursing New Zealand*, Oct. 19.

⁷¹⁷ New Zealand Nurses' Organisation. (2000). Advanced nursing practice: NZNO position statement, June. Retrieved 8 February 2005 from <http://www.nzno.org.nz/SITE>.

⁷¹⁸ NZNO, 2000.

Rather remarkably, it cited the Ministerial Taskforce Report in its bibliography.

In 2001, NZNO took the lead in initiating the formation of a collaborative organisation to work with the Nursing Council in the credentialing process for Nurse Practitioners.⁷¹⁹ Comprised of representatives of NZNO, the ANZCMHN, the National Council of Maori Nurses and the C.N.A. (NZ), the Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ) subsequently developed a memorandum of understanding with the Nursing Council, and initiated a body of work “relating to the endorsement of Nurse Practitioners and the development of the Nurse Practitioner model in Aotearoa, New Zealand”.⁷²⁰

Conclusion

The reforms of the late 1980s and early 1990s set in motion a flow of factors conducive to the growth of nursing knowledge and research; and an expansion of nursing’s sphere of influence and its jurisdiction. The health reforms of that period clearly signaled opportunities for individual nurses and the profession as a whole to make changes which would help to address population health inequities. However, many of the same factors conducive to nursing’s professional project were also inauspicious. The extent and pace of the health reforms had also created a strong counter-current.

In this environment, New Zealand’s oldest, largest professional nursing organization struggled to focus. It became largely captured by a desire to become a “super-union”- “a nursing and midwifery and allied health workers organization, representing as many health workers as possible”.⁷²¹ NZNO seemed to be caught in its own particular whirlpool.

⁷¹⁹ Williams, K. & Gerritson, J. (2001). Practitioner approval body. *New Zealand Nursing Review*, June, 3.
Neville, S. (2002). The Nurse Practitioner Advisory Committee of New Zealand. *Te Puawai*, July. Retrieved 20 September 2003 from <http://www.nurse.org.nz/TePuawai/0702/0702Neville.html>

⁷²⁰ The Nurse Practitioner Advisory Committee of New Zealand, *Newsletter Three* (2003). Christchurch: Author.

⁷²¹ News and events. (1995). Questions to consider on extended membership. *Kai Tiaki: Nursing New Zealand*, April, 5.

Largely as a response to NZNO's perceived inability to balance professional matters and industrial issues, the College of Nurses, Aotearoa was established in 1992. Its first President, Jenny Carryer, then a Manawatu Polytechnic nursing lecturer, set about articulating a nursing position, grounded in scholarship, and focused on health needs. Her political astuteness saw the College become a very influential political force in spite of its small size.

After a hiatus of ten years, strong, visionary nursing leadership also reappeared in the Ministry of Health. In years just prior to her appointment to the Ministry, Frances Hughes had garnered CTA funding for an innovative post-registration nursing programme, and established the New Zealand branch of an Australia and New Zealand College of Mental Health Nursing. As Chief Nursing Officer, Hughes coupled her passion for nursing with adroit political sense.

Appointed Chair of the Nursing Council at her first meeting in 1996, Judy Kilpatrick was a "force to be reckoned with".⁷²² It was under her driving leadership that the frameworks for post-registration nursing education and nurse-prescribing were developed by the Council. With Kilpatrick at the helm, a heretofore, somewhat naïve Council functioned as a more politically aware organization.

These three policy entrepreneurs, scanning the political and health horizon, focused on opportunity, rather than risk. In their positions of national leadership, they were able to drive significant change. They were supported and assisted by a number of other highly capable and astute nurses in NETS, NENZ and other organizations who contributed to various working groups, the Taskforce, individually and collectively. By the late 1990s, a coalescing of critical internal factors was occurring: a strong system of undergraduate nursing education, and the potential for further postgraduate development; an international body of nursing research, and significant potential in the further development of New Zealand nursing research; and a growing number of highly skilled and articulate nurse-specialists/advanced nurse practitioners.

⁷²² Interview with J. Carryer 22 October 2002.

New Zealand nursing's development has international parallels. Forty years earlier in the United States, nurses drew on similar social, political and professional conditions to enable the development of clinical nurse specialists and nurse practitioners. Speaking of the development of Nurse Practitioners in the United States, Loretta Ford noted, "the nurse practitioner movement is one of the finest demonstrations of how nurses exploited the trends in the larger health care system to advance their own professional agenda and to realise their great potential to serve society".⁷²³

⁷²³ Bigbee, J. (1996). History and evolution of advanced nursing practice. In Hamric, A. Spross, J. & Hanson, C. (1996). *Advanced nursing practice: An integrative approach*. (pp.3-24). Philadelphia: W.B. Saunders Company, 18.

Chapter 9: Conclusion

We must forget the beginnings and ends, and make history the endless successions of middles that it is.⁷²⁴

Nursing history: A river runs through it

The river is a powerful image: changing, but timeless; its traces still present even when the river has altered its course. As in Norman Maclean's novella, *A River Runs Through It*,⁷²⁵ this thesis has drawn on the river's image – as a metaphor for this historical research project and its several streams of methods – and also in the sense of the river current as the present time. This thesis has demonstrated the importance of history to understanding the past; the relevance of history to the shape of the present, and of history's influence on the future. Through a sweeping journey from 1860 through the first years of the 21st century, this study has explored what New Zealand nursing was, what it is ceasing to be and what it is becoming.

Beginning with the question, “what are the forces and the voices influencing the meaning of the concept, and the development of advanced nursing practice in New Zealand in the 1990s,” six historical understandings of the meaning of advanced nursing practice emerged. Each of these historical connotations of advanced nursing practice - nurses with higher education; nurses with more than one type of registration; community nurses; nurse educators and administrators; specialty nursing; and a hierarchy of career pathways based on further education, experience and clinical focus – is reflected in the contemporary advanced nursing practitioner.

My initial question was “why there has been a momentum toward advanced nursing practice in New Zealand in the 1990s?” The corollary of this question was “what are the professional and sectoral forces influencing this?” My analysis of forces over the broad scope of New Zealand nursing history as they related to the contemporary

⁷²⁴ Abbott, A. (1988). *The systems of professions: An essay on the division of expert labour*. Chicago: The University of Chicago Press, 32.

⁷²⁵ Maclean, N. (1989). *A river runs through it*. Chicago: University of Chicago Press.

advanced nursing practice movement uncovered essential themes of profession and professionalisation; politics and political sophistication; and the professional project. Each of these concepts was carefully analysed and explored in Chapter Two. Constituent elements and forces within the various concepts were dissected and reassembled in original representational frameworks.

I have demonstrated that the momentum for what became the drive for the development of New Zealand's Nurse Practitioner and the expansion of nursing's jurisdiction at the turn of the 21st century began long before the 1990s. This study's inquiry into historical understandings of advanced nursing, the forces and voices shaping those expressions, and the interpretation and implementation of a contemporary version of advanced nursing practice, has been a study of New Zealand nursing's professional project – its drive to achieve a preferred position in the context of time.

The foreword to *The Nurse Practitioner Standards Project* notes that

The advent of the role of nurse practitioner is a pivotal and historic development in expanding the scope and extent of professional nursing activity and an important contribution to the health and well-being of the...community.⁷²⁶

However, this thesis does not privilege the present by portraying the Nurse Practitioner as the culmination of nursing's development, or suggesting that nursing will continue to develop along similar pathways. This thesis has demonstrated that while the course of action of a professional project is not always clear or deliberate for all the members of the profession - it nevertheless has a coherence that may be seen *ex post facto*. From some future vantage point the Nurse Practitioner may well be seen as just one past step of the project.

⁷²⁶ Australian Nursing and Midwifery Council. (2004). *The Nurse Practitioner standards project: Report to the Australian Nursing and Midwifery Council*. ACT: Author, i.

From Nightingale to New Zealand Nurse Practitioners

Florence Nightingale established nursing's professional project on an international scale. The New Zealand nursing project commenced with the arrival of Nightingale disciples, and shortly thereafter, the establishment of the first training programme at Wellington Hospital. A system of training and a market was rapidly accepted.

New Zealand's first national director of nursing, Grace Neill, Assistant Inspector of Hospitals, Asylums and Charitable Aid, was the visionary whose efforts led to New Zealand enacting the world's first national nurses registration act in 1901. Neill also forged early and influential international networks through her participation in the 1899 International Council of Women Congress, and in the establishment of the International Council of Nurses that same year.

New Zealand's small population and its geographical isolation meant that international links were prized by New Zealand nurses. The country's highly centralised government, the hierarchical nature of nursing and the interwoven relationships across the Division of Nursing, the Nurses and Midwives Board, SANS and NZNA over many decades, meant that often one powerfully positioned person, generally the Director, Division of Nursing was involved across a wide national and international spectrum of nursing activities. This created potential for influence ranging from constricting control to liberating leadership.

Examining the work of a range of nursing leaders, and drawing on the work of John Kingdon, I have described the work of several nurses as "policy entrepreneurship".⁷²⁷ Grace Neill, Flora Cameron, Shirley Bohm, Margaret Bazley, Judy Kilpatrick, Frances Hughes and Jenny Carryer exemplify the nursing policy entrepreneur. This thesis has demonstrated how these leaders created solutions for problems, engaged the attention of policy makers, other influential people and/or the public, and led key campaigns in New Zealand nursing's professional project.

⁷²⁷ Kingdon, 1995, 20.

Belich argues that it is often the following, and not the leadership that is the decisive factor,⁷²⁸ and this is born out in my analysis of nursing's professional project. New Zealand nursing's most concerted and sustained political action - the twenty-year drive from the 1950s to 1973 - to establish nursing education within the tertiary education system was characterised by a counter-current of forces over that long period. Post-war nostalgia, the desire for continuity rather than change and political stasis dampened down social, economic and technological exigencies. However, strong, visionary leaders in the Division of Nursing, NZNA and SANS worked collectively, progressively drawing in wider and wider networks. Flora Cameron, Shirley Bohm, Elsie Boyd, Nan Kinross, Margaret Bazley provided intelligent leadership. Margaret Bazley's and Shirley Bohm's individual policy entrepreneurship and political sophistication enabled them to unite the profession, work effectively with policy makers and other key people, gather critical support from influential organizations, and guide their colleagues. As the social and political environment shifted in favour of reforms, nursing was able to effectively advocate its case.

Different times produce different responses. The changes to nursing education and practice during the 1970s and 1980s, followed by changes to the state sector in the 1980s and 1990s, combined to create forces that radically altered dynamics and structures within the profession. Nursing leadership and practice structures were repeatedly reorganized and re-engineered. The reform of the public sector drastically transformed the orientation and management of the state sector, employer-employee contract relations, and the socio-economic fabric of the country. This upheaval, coming after Shirley Bohm's misunderstood separation of activities of the Nursing Council, NZNA and the concerns of the Division of Nursing in the Department of Health, left many nurses feeling adrift.

However, as old nursing structures and leadership platforms were swept away and the traditionally tight nursing hierarchy was opened up, new possibilities were created. Within five years of the first three degree programmes being established in 1992, the qualification for nursing entry-to-practice moved from diploma to degree. By gaining control of its educational processes, nursing had distanced itself from the control of

⁷²⁸ Belich, 2001, 518.

medicine and the hospital. In the separation of the Nursing Council, NZNA and the Department of Health, nursing had the opportunity to create three streams of influence and power. But while these changes created opportunity to strengthen nursing's jurisdiction, they also caused disruption, dislocation and conflict.

Nursing leaders and organisations have been recognised as critical factors for maintaining and extending nursing's jurisdiction. However, differences in education, personal experiences, class, values and beliefs have the potential to cause deep divides in a professional project, and in the turbulence of the late 1980s and throughout the 1990s, this was a common occurrence. My analysis of the conflict of NZNA with nurse educators and the Vision 2000 Committee in the attempt to establish the degree as entry to practice in 1991, and of NZNO's collision with the Ministerial Taskforce on Nursing and the Nursing Council in 1998 powerfully demonstrates this.

It was in this unstable professional environment, that nursing's professional project had been given a new focus - the development of "advanced nursing practice" and the Nurse Practitioner. An era of radical state sector reform had markedly altered the policy milieu, and three visionary and politically astute leaders – Jenny Carryer, Executive Director of the College of Nurses Aotearoa, Frances Hughes, Chief Nurse, Ministry of Health, and Judy Kilpatrick, Chair, Nursing Council of New Zealand – focused on the opportunities for nursing, foreshown in the health reforms, to make more significant contributions to health care. Employing politically sophisticated approaches, including policy entrepreneurship and effective networking, they were able to drive significant change.

In 2001, the centenary year of New Zealand nursing registration, Deborah Harris became New Zealand's first Nurse Practitioner. By the end of 2004, twelve Nurse Practitioners had been endorsed by the Nursing Council. In the latter part of 2004, arising from the Health Practitioners Competency Assurance Act (2003), the Nursing Council designated four scopes of practice, replacing the six registers for comprehensive, general, general and obstetric, psychiatric, psychopaedic, obstetric nurses; and the roll of enrolled nurses.⁷²⁹ The new scopes of nursing practice are

⁷²⁹ Nursing Council of New Zealand. (2004). *News Update*. November. Wellington: Author.

described under the titles: Nurse Practitioner, Registered Nurse, Nurse Assistant and Enrolled Nurse.⁷³⁰

Nurse Practitioners are described in the Nursing Council scope statement as:

...expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practice both independently and in collaboration with other health care professionals to promote health, prevent disease and diagnose, assess and manage people's health needs. They provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse Practitioners may choose to prescribe medicines within their specific area of practice. Nurse Practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities in local and national policy development.⁷³¹

Groundwork for New Zealand's advanced practitioner was laid in the University of Otago five-year Diploma in Nursing. When this was lost, Mary Lambie, Janet Moore and those who followed them at SANS sustained the ideals of higher education for nursing: practice based on knowledge and scholarship; and later on inquiry and research. Early public health nurses, Native Health nurses, and other community nurses in the tradition of Sybilla Maude established nursing's claim to primary health care well before the Nurse Practitioner was recognised as a key to primary health.⁷³²

⁷³⁰ The Enrolled Nurse title is reserved for enrolled nurses who qualified prior to 2000. Nurse Assistant is the new title for persons who have completed a Nursing Council approved programme of study and other requirements which previously led to the title Enrolled Nurse. The scopes of practice for Enrolled Nurse and Nurse Assistant are slightly different. Nursing Council of New Zealand. (2004). *News Update*. November. Wellington: Author, 4-5.

⁷³¹ Nursing Council of New Zealand. (2004). *News Update*. November. Wellington: Author, 4.

⁷³² Ministry of Health. (2002). *Nurse practitioners in New Zealand*. Wellington: Author, iii. Nursing Council of New Zealand. (2001b). *The Nurse Practitioner: Responding to health needs in New Zealand*. Wellington: Author, 7.

Specialty nurses such as pioneering coronary care and intensive care nurses helped to blur the artificial, modern-day demarcation between care and cure, and provided paradigms for the expansion of nursing's scope of practice. Indeed, "contemporary practices are historically embedded."⁷³³ Today's Nurse Practitioners are an expansion of nursing's capacity to address society's health needs.

The contribution of this thesis

This thesis provides a particular contribution to New Zealand nursing history. Through the broad journey from 1860 through the first years of the 21st century, this study has described the forces and voices in New Zealand nursing's professional project and has revealed the development of advanced nursing practice, historically and contemporarily. My explication of the concepts of profession, professionalisation, political agenda-setting and political sophistication provides a perspective beyond that in other New Zealand nursing histories.

This study has also recorded the personal perspectives and experiences of past nursing leaders which have not previously been told, and which in some cases, such as Elsie Boyd and Shirley Bohm, are little known. The context and the character of their leadership are critical to understanding our heritage.

My analysis of the historical understandings of the meaning of advanced nursing practice counteracts the potential for cultural amnesia or King's "sandcastle culture".⁷³⁴ In demonstrating how each of these historical connotations of advanced nursing practice - nurses with higher education; nurses with more than one type of registration; community nurses; nurse educators and administrators; specialty nursing; and a hierarchy of career pathways based on further education, experience and clinical focus – is reflected in the contemporary advanced nursing practitioner, I have laid the

⁷³³ Tuchman, G. (1994). Historical social science: Methodologies, methods and meanings. In N.K. Denzin & Y.S. Lincoln, eds. *Handbook of qualitative research*. (pp. 306-323). Thousand Oaks: Sage Publications, Inc., 310.

⁷³⁴ King, M. (1985). *Being pakeha*. Auckland: Hodder and Stoughton, 186-187.

groundwork for a future examination of the Nurse Practitioner as not a beginning nor an end of nursing's development.

APPENDICES

Appendix One

Massey University Human Ethics Committee Approval

The following pages include documents relevant to the Massey University Human Ethics Committee Approval for this research

Massey University Human Ethics Committee
c/- EXMSS House, Turitea

Telephone: 64 6 350 5799, extn 2360
Email: P.Dewe@massey.ac.nz
<http://www.massey.ac.nz/~muhec>



Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

15 November 1999

Ms Susan H JACOBS
PG Student
Health Sciences
TURITEA

Dear Susan

**Re: Human Ethics Application – MUHEC 99/145
“The development of advanced nursing practice in New Zealand”**

Thank you for your letter of 31 October 1999 and the enclosures.

The amendments you have made now meet the requirements of the Massey University Human Ethics Committee and the ethics of your application are approved.

Yours sincerely

A handwritten signature in black ink, appearing to read "Philip Dewe".

Professor Philip J Dewe
Chairperson
Massey University Human Ethics Committee - Palmerston North

cc Professor Julie Boddy
Health Sciences
TURITEA

Associate Professor Margaret Tennant
History, Philosophy & Politics
TURITEA

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

The development of advanced nursing practice in New Zealand.

INFORMATION SHEET

Dear

Introduction:

I am undertaking research regarding the development of advanced nursing practice in New Zealand for a PhD thesis. Because of your understanding and experience of the factors and forces influencing developments in nursing education and practice, you are invited to take part in this study.

Researcher:

Susan Jacobs
PhD student
209 Poraiti Rd.
RD 2
Napier
Telephone (home):
06-844-6610

Supervisors:

Dr. Julie Boddy
Head of School
School of Health Sciences
Massey University
Palmerston North
Telephone:
06-350-5799, ext 2541

Dr. Margaret Tennant
Assoc. Professor
School of History,
Philosophy and Politics
Massey University
Telephone:
06-350-4236

(Susan is the Dean of Health Studies at the Eastern Institute of Technology. Her work telephone number is 06-844-8710, ext. 5411. Email: sjacobs@eit.ac.nz)

Your participation in this study would involve:

Taking part in an interview with the researcher of approximately one hour in duration, at a time and place that is mutually agreeable. With your consent, the interview will be audio-taped.

Aim of the study:

To identify and critically analyse the forces and voices influencing the meaning of the concept, and the development of advanced nursing practice in New Zealand.

Participant selection:

I am approaching you because you are known:

- 1) to have been/be involved in the development of programmes of education for nurses, and/or
- 2) involved in influencing policy related to the development of advanced nursing practice in New Zealand.

Participants will be volunteers. Research participation is optional.

- You have the right not to take part in the study.

Te Kūnenga ki Pūrehurua

Inception to Infinity: Massey University's commitment to learning as a life-long journey

- You have the right not to answer any particular questions posed by the researcher.
- You have the right to ask questions about the study at any time during your participation.
- You have the right to withdraw from the study at any time. If you decide to withdraw during the study, the researcher will clarify with you whether you are happy for data you have provided to be used in the study, or if you wish the tapes and/or notes of your interview to be returned to you.
- Your name will not be used unless you give permission to the researcher.
- You have the right to a summary of the findings of the study when it is concluded.

Research method:

The research methods will be history and discourse analysis. This would involve you answering questions posed by the researcher, related to the research title.

The interviews will be tape-recorded (though you may request that the tape be turned off at any time). After the interview, the tape will be transcribed by a dictaphone typist. The typist will have signed a confidentiality agreement prior to commencing work.

The researcher will provide you with a summary of the transcribed interview, including any comments which may be ascribed to you. You will be requested to ensure it is accurate, and to clarify any points. You may keep the copy of the transcribed interview. If you wish, the researcher will provide you with a copy of the tape-recording of the interview.

Once all the interviews are complete, the researcher will analyse the data.

A full research report will be made available to Massey University for marking purposes. You will be offered a summary of the final research results. Articles describing the research may be later published in appropriate journals or books and/or presentations given at a conference.

Confidentiality:

No information that could identify you will be used in any reports without your permission. Should you wish not to have your name used, a description of your relevant role in nursing will be used. Given the nature of your involvement in nursing, your identity may be discerned by readers of the research report or articles arising from the report. You may choose or not choose to participate in the study based on these understandings.

Audio-tapes and transcripts will have all identifying data deleted. The transcriber will have signed a confidentiality statement prior to be engaged. All records will be kept in a locked place. At the completion of the research, you will be given the options of the tapes being either destroyed or returned to you, or possibly being considered for archiving. The transcripts of the interviews will be destroyed five years after the completion or termination of the study.

On-going notes and results will be checked by the research supervisors, Dr. Julie Boddy and Dr. Margaret Tennant.

Risks and benefits of participating in the study:

It is not anticipated that you be at any risk due to your participation in this study

Benefits of the study include the opportunity to have your participation in the development of nursing be included in the research report. Your participation may contribute to understandings about the

meaning of advanced nursing practice, about the history of nursing in New Zealand, and may further the development of advanced nursing practice.

Ethical approval:

This study has been approved by the Massey University Ethics Committee

The development of advanced nursing practice in New Zealand

CONSENT FORM

I have read the Information Sheet, and have had the details of the study explained to me. I have had time to consider whether to take part. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that:

- a) Taking part in this study is voluntary.
- b) I may withdraw from the study at any time.
- c) I may decline to answer any particular questions.
- d) I have the right to ask for the audio-tape to be turned off at any time during the interview.
- e) I may request a copy of the audio-tape of my interview, and that at the completion of the research, I will be given the options of the original audio-tape being either destroyed or returned to me, or possibly being considered for archiving.
- f) Information obtained will be used only for this research and publications or presentations arising from this research project.

I agree / do not agree to the interview being audio-taped.

I agree to participate in the study under the conditions set out in the Information Sheet.

This project is approved by the Massey University Ethics Committee. This means that the Ethics Committee may check that this study is running smoothly and that the study has followed ethical procedures.

Signed: _____

Name: _____ Date: _____

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

I agree / do not agree for my name to be used by the researcher in the thesis and publications or presentations arising from this research.

Signed: _____

Name: _____ Date: _____

The development of advanced nursing practice in New Zealand

CONSENT FORM

The development of advanced nursing practice in New Zealand

Undertaking as to non-disclosure of information

Whereas, I _____, currently residing at

have agreed to transcribe tapes made during interviews conducted by Susan Jacobs, for the purposes of a research project, will as a part of the transcription process, hear names and other forms of identification of people I therefore AGREE:

- a) That I will not, at any time directly or indirectly share or divulge any information concerning the identification of participants and/or identifiable people, and/or identifiable institutions to which I have been given access.
- b) I also undertake that I will not at any time, either directly or indirectly, divulge to any person, department, agency or institution, information to which I have been given access.
- c) That I will not retain any copies of the transcriptions on computer hard drive, computer disk, or on paper after submitting transcriptions to the researcher.

I understand that only Susan Jacobs, the researcher, Dr. Julie Boddy and Dr. Margaret Tennant, the research supervisors, and the particular research participant will be allowed access to the information on the tape(s).

I understand that should a participant withdraw from the study, the participant will have the option of having the data used in the study, but without any further participation from the participant. Alternatively, the participant may request that the tapes, notes and transcripts be returned to her/him and that no data from that participant-interview be used in the study.

Name: _____ Witness (name): _____

Signed: _____ Signature of witness: _____

Date: _____ Date: _____

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

Appendix Two

New Zealand Nursing Chronology

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1860								The Nightingale Training School, an independent school, financed by the Nightingale Fund, opened at St Thomas Hospital, London.
1882						Thirty-seven provincial hospitals in existence		
1883			First nursing training programmes in NZ established at Wellington Hospital.					
1889								
1893					Grace Neill appointed Inspector of Factories		Women right to vote, NZ	
1895			By 1895, nursing training had been established in Auckland, Dunedin and Waikato Hospitals, as well as Wellington.		Grace Neill appointed Assist Inspector of Hospitals, Asylums and Charitable Aid.			
1896						Sybilla Maude left her position as Matron of Christchurch Hospital to commence district nursing.		
1899								International Council of Women meeting in London. Grace Neill presented paper, "Professional Training and Status of Nurses" at the Nursing Section of the meetings. This advocated 3-year training and a state examination by a central board of examiners leading to statutory registration. G. Neill was part of the committee which met during the ICW meeting, led by Ethel Gordon Fenwick, which proposed the International Council of Nurses (ICN).
								Provisional Committee of the ICN approved its constitution.

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1901		Nurses Registration Act passed.						First formal meeting of the ICN in Buffalo, New York.
1902								
1903								
1904		Midwives Registration Act						
1905	Wellington Private Nurses' Assoc founded.							
1906					Grace Neill retired. Hester Maclean succeeds her as Assist Inspector of Hospitals Asylums, & Charitable Institutions. In this post from 1906-1923.			
1907	Dunedin Trained Nurse' Assoc founded.					Royal Society for the Health of Women and Children (Plunket Society) founded.		
1908	Auckland Trained Nses' Assoc founded.					<i>Kai Tiaki</i> founded by Hester Maclean.		
1909	New Zealand Trained Nurses' Association founded (NZTNA). Hester Maclean, first President.							
1910								<i>Kai Tiaki</i> published news of the University of Minnesota bachelors degree in nursing.
1911						Native Health Nursing service established.		
1912	NZTNA becomes the 9th member of ICN.		Dr. Pabst of Auckland Hospital in a speech at the opening of a new nurses' home proposed "the university should confer a Degree in Nursing, so recognising what for years had been a profession" (Maclean, 1932 in Kinross, 1984, p.194)					
1913								Hester Maclean named Matron-in-Chief of Nursing Reserve.
1914								New Zealand, as part of the British Empire, enters the war when King George V declares war with Austria-Hungary and Germany. First nsg sisters leave with NZ troops.

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1915								British War Office agrees that New Zealand nurses may provide nursing service to the military troops. NZ Army Nursing Service is established.
1916								
1917								
1918								Influenza pandemic.
1919								England achieved statutory registration of nurses.
1920		Nurses Regulations Amendment Act of 1920 reduced age of registration to 22.			Health Act.-Dept of Health reorganised, and a Division of Nursing established. Hester Maclean first Director.			
1921								
1922	NZTNA, from their Dunedin conference, sent recommendation to Govt for a 5 yr nursing course to be established at University of Otago.		Dir-Gen of Health, Dr. Valentine issued circular to all training schools reporting the complaints of the examiners, and reinforcing the necessity of requiring a Std 6 ed for trainees. Refer "Nursing Professional Organisation", 1922 also.	Refer "Nursing Professional Organisation" 1922 also.	Director-designate Jessie Bicknell, (H. Maclean was due to retire), sent on overseas study leave. She first recommended the establishment of a "post-graduate" school.			<i>Kai Tiaki</i> reports the establishment of a diploma course in nursing at the University of Leeds.
1923	NZTNA purchased <i>Kai Tiaki</i> from Hester Maclean.		Sep, 1923, the University of Otago Council approved in principle the establishment of a Diploma in Nursing.		H. MacLean retired (Oct). Jessie Bicknell, Director, Division of Nursing, 1923-1931			
1924								
1925		Nurses & Midwives Registration Act consolidates the previous separate acts. Constituted the Nurses and Midwives Board. Also, as a result, the Dir. , Division of Nsg became the Registrar.	New category of nurse created--Maternity nurses (1925 Nurses & Midwives Act).		Janet Moore and Mary Lambie sent overseas to prepare for their roles as teachers in the University of Otago programme (London & Toronto respectively). Meanwhile three students enrolled in 1925.			

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1926	Kai Tiaki registered as the official journal of NZTNA	Nurses and Midwives Amend. Act of 1926 changes the age of registration back to 23.		J. Bicknell returned in late 1923 after seeing post-grad nsg devel overseas; and Dr. Valintine wrote to University of Otago Council, suggesting the 5th year of the diploma programme be set up so that registered nurses could be admitted to the 5th year directly. Committee decided to begin the 5th year in 1926 (before a first cohort would have gone through).	Dispute over the payment of salaries of J. Moore and M. Lambie, and in spite of extensive negotiation among NZTNA, Dept Health, University of Otago, the Council deleted the Dip of Nsg from its calendar 19 Oct 1926.			
1927	NZTNA interest sections established: nursing education, public health nursing, private nursing.			M. Lambie and J. Moore discussed postgraduate course ideas with Dr. Valintine and Miss Bicknell; also made contact with Prof. Hunter at Victoria University.				
	Council of New Zealand Hospital Matrons formed.							
1928				Following Treasury approval, Postgraduate School for Nurses established. First course began in Feb, 1928 in Wellington Hospital. Lambie and Moore inaugural instructors.				
1929								
1930	NZTNA Associate membership extended to mental nurses with 3yr training certificate.	Nurses & Midwives Amendment Act 1930 provided the Nurses and Midwives Board with the right to approve private hospitals as training institutions, and to limit both public and private hospitals to certain areas of instruction.						
1931					Mary Lambie became Director, Division of Nursing, and served 1931-1950.			
1932	NZTNA becomes NZ Registered Nurses' Association (NZRNA).					Hester Maclean died.		
1933								
1934								

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1935	Jessie Bicknell, President, NZRNA, 1935-37			Elizabeth Bridges, then Assistant Matron of Southland Hospital - the recipient of the first National Florence Nightingale scholarship, 1935. Went to Bedford College, London for a year.				
1936								Mary Lambie received Rockefeller Foundation Scholarship to study in North America and Europe.
1937	Cecelia McKenny, President, NZRNA, 1937-43							
1938								
1939		Nurses & Midwives Regulation Act amendment - annual practising certificates introduced.				Social Security Act		New Zealand declared war on Germany, 3 September, and enters World War II.
1940				Elizabeth Bridges and Flora Cameron appointed to the Postgraduate School for Nurses.				
1941								
1942							Industrial Manpower Act: hospitals regarded as essential industries.	
1943	Lillian Maria Banks, Pres. NZRNA, 1943-46	Nurses & Midwives Amendment Act 1943-reduced age of registration for general nurses to 21.						
1944								
1945		Training and registration of psychiatric nurses to come under control of Nurses & Midwives Board.						
1946	Nora Fitzgibbon, Pres., NZRNA, 1946-49	N&M Reg Act amendment: established the training and registration of male nurses.						
1947							NZ Parliament ratifies the Statute of Westminster, which gave NZ autonomy in foreign as well as domestic affairs. NZ was the last dominion to ratify this statute- most has ratified it in 1931.	

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1948				The first clinically-oriented post-registration courses introduced - Otago Hospital Board introduced a course in neurosurgical nursing, and the North Canterbury Hospital Board, established a plastic surgery nursing course.				First World Health Organization (WHO) Assembly
1949	Dorothy Buchanan, Pres, NZRNA, 1949-52					Physiotherapy Act, and Occupational Therapy Act		
1950					Flora Cameron appointed Director, Division of Nursing			WHO Expert Committee on Nsg
1951								
1952	Jessie Martin, Pres, NZRNA, 1952-56							
1953								
1954								
1955								Elsie Boyd then a tutor-sister at Auckland Hospital, received the NZ scholarship of the British Commonwealth Fund, and studied at the Royal College of Nursing, London.
1956	Eilenn Fosberry Chambers, Pres., NZRNA, 1956-60		Curriculum changes instituted by the Nurses and Midwives board included the incorporation of obstetric nursing into general nursing, and attempts at conceptual changes to include health, family and community approaches and linking theory with practice.					ICN organised the first international nursing research conference, held in Sevres, France.
1957	NZRNA formally recognised by Govt as the voice of nurses in NZ; but not til 1969 that officially recognised as the official body representing nurses in general and maternity hospitals for the negotiation of wages, salaries and conditions of employment.	N&M amendment Act- reduced the age of registration of general nurses to 20; psychiatric nursing registration remained at 21. Provided for maternity training to be included in general nurses' training.						
1958								

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1959								
1960	Winifred Train, Pres., NZRNA, 1960-64	N&M Reg Act amendment: established training and registration of psychopedic nurses. Created Deputy-Registrar role--to be carried out by the Dep-Dir, Division of Nursing, Dep Health.			Shirley Bohm (then S. Lowe) appointed Nurse Adviser, Dept Health.		Equal Pay Implementation Commission	Beatrice Salmon awarded British Commonwealth Fund scholarship to complete Bachelor of Nursing at McGill University.
1961								
1962		N&M Brd Sub-Committee: 2nd level nse						ICN Brd of Directors' meeting, Wellington
1963		Community nse pilot @ Wairau Hospital (NZNA, 1984)			Audrey Orbell appointed Director, Division of Nursing to replace Flora Cameron			
1964	Ena Hollis, Pres., NZRNA, 1964-6	Nurses and Midwives Board adopted <i>A Plan for Nursing in New Zealand</i> which called for 3 educational approaches: a pre-registration degree, a general 3-year hospital programme, and a 15-month community nurse programme.			S. Bohm (then S. Lowe) appointed Assist. Director, Division of Nursing.			
1965		N&M Reg Act amendm't: registration of Community Nurses; and minimum entry requirement for general nursing programme set at School Certificate.				Prof Alma Reid's visit (funded by the University Grants Committee). <i>Her Report on Nursing Education in New Zealand (1965) completed.</i>		
1966		M. Bazley, member N&M Board 1966-72. (Later a member of the Nursing Council).			S. Bohm appt'd Director, Dvnsion of Nursing - retired 1978	July, 1996 University Grants Committee considered A. Reid report, rejecting its recommendations.		Elsie Boyd received WHO Traveling Fellowship to study in the United States.
1967		N&M Amendmt Act "some language altered to reflect non-gender-specific words, such as person rather than woman" (French, 1998, Appen A).			Nan Kinross, Assist Director, Division of Nursing 1967-73; Elsie Boyd appointed to newly-established position of Assist Director, Nursing Education -1967, retired 1980.	Nursing Education and Research Foundation established (NERF).		
1968	Enyth Holdgate, Pres., NZRNA, 1968-72							
1969					<i>Review of Hoospital and Related Services</i> published.	State Services Condition of Employment Act, 1969 recognised NZRNA as negotiating body for nurses in public sector.		Judith Christensen awarded Flora Cameron Scholarship to complete her MA (Applied) at McGill.

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1970	NZRNA joined Combined State Services Org (subsequently Combined State Unions)(NZNA, 1984, p.170)			Postgraduate School for Nurses renamed School for Advanced Nursing Studies (SANS).		Dr Helen Carpenter - WHO consultant to New Zealand.		
1971	NZRNA became NZNA.	1971 Nurses Act created the separate registration authority in the Nursing Council of New Zealand. Established the Nursing Council as a corporate body. Excluded midwifery in the title of the Act but continued to be the statutory authority for midwives until the Health Practitioners Competency Assurance Act (2003).			Health Amendment Act, 1971 replaced the SANS Management Committee with an Advisory Committee--to "advise the Director-General on selection of students; development and implementation of the curriculum; and evaluation of students" (SANS 1 Index to the files)	Dr Carpenter's <i>World Health Organisation Assignment Report</i> published; recom 1.6 that the Minister of Education appoint a committee to make further recommendations to Govt on a proposal for the development of colleges of health science for the preparation of nurses and other categories of health service staff.		
1972	Margaret Bazley, Pres NZNA, 1972-74. "Operation Nurse Education" initiated.	Dulcie Newman, Chairperson, Nursing Council, May 1972 - Aug 1973. Shirley Bohm, Acting Registrar, April 1972 - Dec 1972. H. R. Ligtenberg, Registrar/Chief Executive, Nursing Council, Jan 1972 - Dec 1984				"1.6 Committee" reports findings to Minister of Education. (Sept, 72) <i>Nursing Education in New Zealand.</i>	Labour elected- Norman Kirk Prime Minister. Accident Compensation Act established the Accident compensation Corporation.	
1972, cont	Nurses Society established.					Psychiatric and psychopaedic nurses employees of Dept of Health until 1972, when the admin of mental hospitals, excepting Lake Alice Hospital was transferred to local hospital boards. Mental hospital staff, including registered nurses continued to be represented by the Public Service Association (PSA).		
1973		Brian Laity, Chairperson, Nursing Council, Nov 1973 - May 1975	The first comprehensive nursing programmes established at Wellington and Christchurch Technical institutes.	Post-registration nursing courses established at Massey and Victoria Universities.				
1974	Margaret Lythgoe (Pickard) Pres, NZNA, 1974-77		Nelson Technical Institute comprehensive nursing pilot programme commenced.				Norma Kirk dies suddenly.	

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1975		Anne Nightingale, Chairperson, Nursing Council, May 1975 - May 1984	Auckland Technical Institute comprehensive nursing pilot programme commenced.				National elected. Robert Muldoon Prime Minister, 1975-1984	
1976	NZNA: <i>Policy Statement on Nursing in NZ: New Directions in Post-Basic Ed</i>		Gov't approves continuation of established programmes on an indefinite basis rather than year by year approval.					
							Gov't established the Student Tertiary Bursary system.	
1977	Joy Motley, Pres, NZNA, 1977-80	Nurses Act 1977 "allowed for regis of comprehensive nses from technical insitutes. Removed cat of commun nse and created title enrolled nse. All existing comm nses were trans to the Roll. Removed age criteria for regis, except for enrolment of E.N.s" (French, 1998, Appen A).						
1978			Waikato and Southland Technical Institutes approved to commence nursing diplomas.	SANS closes, November	M. Bazley, Director, Div of Neg, 1978-1987			
1979				Advanced Diploma in Nursing programmes established at Auckland Technical Institute, Wellington Polytechnic, and Christchurch Polytechnic.				
1980	Marie Burgess, Pres, NZNA, 1980-82		Manukau and Palmerston North Technical Institutes' nursing programmes start.	Advanced Diploma in Nursing begins at Waikato Technical Institute.				
			"Bridging" courses introduced to bridge RGON, RPsyN, R Psychped to RCpN.				Sep 1980 Govt approved 3-year rolling plan for introduction of new nursing programmes.	
1981			Hawke's Bay Community College comprehensive nursing programme commenced.					
1982	Sue Burrell, Pres, 1982-1984.		Taranaki Technical Institute nursing programme commenced.			<i>An Evaluation of Nursing Courses in Tech Institutes</i> published		

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1983		1983 Nses amend Act "inserted the requiremt for E.N.s to prac under direction and supervision of reg nses or med practi.(French, 1998, appen A).	Northland Polytechnic nursing programme commenced.	Nan Kinross appointed as Chair of Nursing, at Massey University.--First Chair of Nursing in Australasia.			Area Health Boards Act (1983)	
1984	Jocelyn Keith, President, NZNA, 1984 - 1987. Patricia Carroll, Executive Director, NZNA, 1984 - 1986. NZNA published <i>Nursing Education in New Zealand: A Review and Statement of Policy.</i>	Nancy Neilson, Chairperson, Nursing Council, May 1984 - May 1987	Otago Polytechnic nursing programme commenced.				Labour elected. David Lange, Prime Minister.	
1985		P. H. Redpath, Registrar/Chief Executive, Nursing Council, Jan 1985 - Ddec 1985 J. F Hiess, Registrar/Chief Executive, Dec 1985 - Aug 1986	Wairiki Polytechnic nursing programme commenced.	Number of government-funded places in A.D.N.s increased from 150 to 200 places.				
			Bridging courses expanded.					
1986		I C Chote, Registrar/Chief Executive, Nursing Council, Aug 1986 - Oct 1989	Carrington & Paramoana Technical Insitute (Unitec & Whitireia) nursing programmes commence.			<i>Review of the Initial Preparation and Employment of Nurses</i> published.		
1987	Lorraine Sivyer, Pres., NZNA, 1987 - 1990 Gay Williams, Executive Director, NZNA, 1987 - 1994.	Allison Chappell, Chairperson, Nursing Council, May 1987 - July 1990					Labour re-elected- David Lange, PM	
							Labour Relations Act (1987)	
1988							David Lange re-signed. G. Palmer, then M. Moore, Labour PMs	
							State Sector Act (1988)	
1989		Marie Burgess, Registrar/Executive Director, Nursing Council, Oct 1989 - Oct 1994; Registrar, Nov 1994 - Mar 1995		Norma Chick, PhD (psychology) appointed Professor, Nursing Studies and Head of Department, Nursing, Massey University.		Judith Christensen awarded Australasia's first PhD in nursing.		
							Education Amendment Act (1989)	

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1990	Helen MacKensie, Pres., NZNA, 1990 - 1993.	Elaine Papps, Chairperson, Nursing Council, Oct 1990 - May 1996				Nurses Amendment Act 1990- enabled independent midwifery practice w/ access to hospitals, lab and diagnostic tests, prescribing rights, and government payment for services.	National elected- Jim Bolger, Prime Minister, 1990- 1997	
1991						Vision 2000: Project 1991 Forum held, Auckland, Mar14/15, 1991	Employment Contracts Act (1991) in effect-no compulsory unionism; permitted individual contracts	
						May 1991 Forum Report published by NZNA on behalf of the organising committee of Vision 2000: Project 1991.		
1992	College of Nurses Aotearoa (NZ) established. Founding President, Jenny Carryer.		Otago Polytechnic begins 3 year BN. AUT begins 4-year B.H.Sci (Nsg). Wellington Polytechnic begins 4-year B.H.Sci. (Nsg). (These 4-year programmes revised within the next year to 3-year degree programmes.)			<i>A Framework for Nursing and Midwifery Education: a Discussion Paper</i> (Natali Allen) published, by the Vision 2000 committee, Jan,1992		
	Nurse Education in the Tertiary Sector (NETS) officially established.							
1993	NZNA and the Nurses' Union amalgamate to form the New Zealand Nurses' Organisation (NZNO). Helen MacKensie and Margaret Flavell, Joint Presidency, NZNA/NZNO, 1993-1994							
	ANZCMHN established. Frances Hughes, founding President.							
1994	Nigel Kee, President, NZNO, 1994 - 1997. Gay Williams and Steph Breen, National Directors, NZNA/NZNO; then Mary Gibbs, Acting National Director, 1994	Allison Chappell, Acting Chief Executive Officer, Nursing Council, Nov 1994 - Jan 1995; B. Greer, Registrar/Legal Adviser, Feb 1995 - July 1998.				Prof John Shaw's paper published-- <i>Prescribing rights in New Zealand: A public discussion paper.</i> Wellington: Ministry of Health		

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1995	Brenda Wilson, National Director, NZNO, 1995 - 1998; then 1998 - 2000 when title changed to Chief Executive	Colleen Singleton, Chief Executive Officer, Nursing Council, Feb 1995 - July 1998						
1996		Judy Kilpatrick, Chairperson, Nursing Council, May 1996 - 2002	By 1996, all institutes offering pre-registration nursing are offering a bachelor's degree (one or two shortened diplomas for enrolled nurses to bridge to registration are still being offered.)		June 1996, Frances Hughes appointed as a senior nursing advisor in the Ministry of Health.			
1997	Judi Mulholland, President, NZNO, 1997 - 2001.			Mar, 1997, <i>Position Statement on Post-registration Nursing Education</i> , endorsed by NETS, NENZ published.	Dec, 97, Frances Hughes appointed Chief Nurse Adviser to Ministry of Health. - (Acting Chief Nsg Adv since June 97.)		Jenny Shipley, Prime Minister, National-led government.	
1998		Marion Clark, Chief Executive Officer (includes responsibilities of Registrar), July 1998 - present. Refer also "Post-registration Nursing Education".		May, 1998, Nursing Council published its first edition of <i>Framework, Guidelines and Competencies for Post-Registration Nursing Education</i> .	Feb, 1998 Minister of Health, Bill English announced establishment of a Ministerial Taskforce on Nursing.			
					April, 1998 Nurse Executives of NZ published <i>Developing & supporting advanced practice roles: Clinical nurse specialist, nurse practitioner</i>			
		Nursing Council agrees that allowing for existing diploma in nursing programmes to phase out, entry to the register of comprehensive nurses would be by bachelor's degree (for those educated in NZ).			May 12, International Nurses Day, Minister of Health, Bill English announces intention to introduce amendment to Medicines Act, 1981 to enable regulations which will permit nurse-prescribing.			
	NZNO published <i>Building Partnerships. Developing the Future of Nursing</i> as response to Ministerial Taskforce Report.				Aug, 1998 <i>Report of the Ministerial Taskforce on Nursing: Releasing the Potential of Nursing</i> published. NZNO withdrew from the Taskforce prior to publication.			

	Nursing Professional Org(s).	Statutory Body/Regulation.	Pre-registration/"Basic" Nursing Education	Post-registration Nursing Education	Depart. of Health/Similar	Other Health/Nursing	Other socio-political	International
1998, cont					Also in Aug. 1998, the Ministry of Health established working groups for nurse-prescribing in aged care and child-family health scopes of practices.			
					Dec 1998, Ministry of Health consultation document: Nurse Prescribing in Aged Care and Child Family Health released.			
1999	Mar, 1999 College of Nurses Aotearoa(NZ) and Ministry of Health host workshop on Advanced Nursing Practice w/ visiting scholar, Sarah Sheets Cook.	Nursing Council published framework for Nurse-Prescribing.			Medicines Amendment Act passed (Oct.) Enabled designated prescribers to prescribe under regulations passed.		Labour-led government elected. Helen Clark, Prime Minister.	
2000	Geoff Annals, Chief Executive, NZNO, 2000 - .	Nursing Council instituted a review of undergraduate nursing education.						
		Nursing Council established a Committee of Council on Advanced Nursing Practice.						
2001	Jane O'Malley, President, NZNO, 2001 -	<i>The Nurse Practitioner: Responding to Health Needs in New Zealand</i> published by Nursing Council. March			First meeting of the New Prescribers Advisory Committee (NPAC), 31 July.			
						December 2001, Deborah Harris endorsed by the Nursing Council as a Nurse Practitioner.		
2002		Annette Huntington, Chairperson, Nursing Council, 2002 - present			<i>Nurse Practitioners in NZ</i> published by Ministry of Health.	Paula Renouf, endorsed as New Zealand's second NP; later to become the first NP endorsed for prescribing in Child Health.	Labour-re-elected. Helen Clark, Prime Minister.	
2003								
2004					Frances Hughes, resigns Chief Nurse position. Pauline Cook, Acting Chief Nurse Advisor.			
2005		Nursing Council distributed a consultation document relating to prescribing for the scope of practice, Nurse Practitioner. (April)						

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