The New Zealand nurse practitioner polemic: A discourse analysis

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Abstract

The purpose of this research has been to trace the development of the nurse practitioner role in New Zealand. Established in 2001, this advanced nursing practice role was birthed amid controversy as historical forces at play both inside and outside nursing struggled for power to control the future of the profession. Using a discourse analytical approach informed by the work of Michel Foucault, the study foregrounds the discourses that have constructed the nurse practitioner role within the New Zealand social and political context. Discourses, as explained by Foucault, are bodies of knowledge construed to be 'truth' and connected to power by reason of this assumption, serving to fix norms and making it virtually impossible to think outside them. Discourses of nursing and of medicine have established systems of disciplinary practices that produce nurses and physicians within defined role boundaries, not because of legislation, but because discourse has constructed certain rules. The nurse practitioner role transcends those boundaries and offers the possibility of a new and potentially more liberating identity for nurses and nursing.

A plural approach of both textuality and discursivity was used to guide the analysis of texts chosen from published literature and from nine interviews conducted with individuals who have been influential in the unfolding of the nurse practitioner role. Both professionally and industrially and in academic and regulatory terms dating back to the Nurses Registration Act, 1901, the political discourses and disciplinary practices serving to position nurses in the health care sector and to represent nursing are examined. The play of these forces has created an interstice from which the nurse practitioner role in New Zealand could emerge.

In combination with a new state regime of primary health care, the notion of an autonomous nursing profession in both practice and regulation has challenged medicine's traditional right to surveillance of nursing practice. Through a kind of regulated freedom, the availability of assessment, diagnostic and prescribing practices within a nursing discourse signals a radical shift in how nursing can be represented. The nurse practitioner polemic has revolutionised the nursing subject, and may in turn lead to a qualitatively different health service.

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List of Abbreviations

ACC	Accident Compensation Corporation
APC	Annual Practising Certificate
ASMS	Association of Salaried Medical Specialists
BN	Bachelor of Nursing
CCP	Clinical Career Pathway
CTA	Clinical Training Agency
DHB	District Health Board
ECA	Employment Contracts Act
GMS	General Medical Subsidy
GP	General practitioner
HORAA	Health Occupational Registration Acts Amendment
HPCA	Health Practitioners Competence Assurance (Act)
HWAC	Health Workforce Advisory Committee
ICN	International Council of Nurses
IPA	Independent Practitioner Association
MOH	Ministry of Health
NCNZ	Nursing Council of New Zealand
NENZ	Nurse Executives in New Zealand
NETS	Nurse Educators in the Tertiary Sector
NP	Nurse practitioner
NPAC	New Prescribers Advisory Committee
NPAC-NZ	Nurse Practitioner Advisory Council New Zealand
NZMA	New Zealand Medical Association
NZNA	New Zealand Nurses' Association
NZNO	New Zealand Nurses Organisation
NZQA	New Zealand Qualifications Authority
NZTNA	New Zealand Trained Nurses' Association
PHO	Primary Health Organisation
QDAS	Qualitative Data Analysis Software
RN	Registered Nurse
RNZCGP	Royal New Zealand College of General Practitioners
SANS	School of Advanced Nursing Studies

Part One: The research framework

This thesis is a discourse analysis of the nurse practitioner polemic in New Zealand and is divided into three parts. The first part outlines the research framework with respect to the study aims, theoretical perspective and methodology; parts two and three are data analysis chapters and conclusions.

Part one comprises three chapters, with chapter one an introduction to the thesis and the aims of the project. There is a brief description of the health and disability sector in New Zealand, with a particular emphasis on primary health care, the role of the Nursing Council of New Zealand in the regulation of nursing scopes of practise under the Health Practitioners Competence Assurance Act, 2003, and the location of the New Zealand nurse practitioner (NP) endeavour within the international context of advanced nursing practice. The overall structure of the thesis is described and an outline of each chapter is provided.

Chapter two considers the theoretical tools used throughout the thesis, drawing predominantly on the work of Michel Foucault and commentators of his work. The assumptions central to a postmodern and post-structural epistemology are explained, as well as Foucault's historical method of analysis, genealogy, which accounts for the way in which subjectivity is constituted by discourse. Disciplinary techniques, governmentality, and technologies of the self comprise the main theoretical tools used to inform the analysis of data collected for this study.

Chapter three outlines the approach used to operationalise a Foucauldian analysis into a research methodology. This chapter is a partner to chapter two and details the specific analytical tools used to examine the various texts informing the study. An account of the steps in the research process is outlined, which includes consideration of the ethical aspects of conducting the study and interviewing participants, qualitative data analysis software, and the process of constructing the final text of the research report.

Chapter 1: Introducing the study

Introduction

> … the notion of interstice is surprising. The play of forces in any particular historical situation is made possible by the space which defines them. It is this field or clearing which is primary (Dreyfus & Rabinow, 1983, p. 109).

These words on the notion of interstice were written about the work of French philosopher Michel Foucault. Emergence, Foucault suggests (1977b, p. 150), "always occurs in the interstice", a space he describes as an endless play of dominations. The emergence of a new nursing identity, as this study examines, has arisen amid an endless play of forces seeking ascendancy through meticulous rituals of power and claims to truth. These forces as discourse have created an interstice from which the nurse practitioner role could emerge.

Interstice normally means the small spaces or openings between things. Nurses are familiar with the anatomical use of the word, where it refers to spaces between cells that are filled with interstitial fluid. Working as a registered nurse (RN) in post-operative surgical wards, the shift of fluids into interstitial spaces has been a focus of attention in my own nursing practice, and also in my capacity as a lecturer teaching anatomy and physiology to undergraduate nurses. Finding the notion of interstice in the work of Foucault was then indeed surprising, but also captivating, particularly as my research interests to date had been concerned with the centrality of power in the nursing endeavour (Wilkinson, 2001a, 2001b, 2002). The word interstice is central to this thesis in a philosophical sense, and refers to the spaces created by historical forces at play both inside and outside nursing.

Ideas of advanced nursing practice came to the forefront of my consciousness as I began my master's degree in 1998, and in class we scrutinised the findings of the Ministerial Taskforce on Nursing. The discursive challenges that transpired during the work of the Taskforce, and in subsequent months and years, defined and cleared a space for a radical shift in perspective of how nursing could be represented. The focus of this study is on the creation of a nurse practitioner role

in New Zealand and the struggle for nurses to achieve "authority over the nature of their practice" (Nurse Executives of New Zealand, 1998, p. 1).

The purpose of this first chapter is to introduce the aim of this project and its context. There is a brief description of the health and disability sector in New Zealand and of the primary care sector. This chapter explains the role of the Nursing Council of New Zealand (henceforth Nursing Council) in the regulation of nursing scopes of practice under the Health Practitioner Competence Assurance Act (HPCA Act) 2003, the centrality of nursing autonomy to the thesis, and the location of the New Zealand nurse practitioner endeavour within the international context of advanced nursing practice. The chapter concludes with a précis of the overall structure of the thesis and indicates the content of each chapter.

Study aims and approach

As with all research inquiry, this study began with an area of interest. The disharmony within the nursing profession and alarm within the medical profession about the introduction of the nurse practitioner role in New Zealand were well reported in the media and in nursing and medical publications around the turn of the century (particularly *Kai Tiaki Nursing New Zealand* and *NZ Doctor*). Concerns were circulated and discussed in nursing circles at length. The topic required an epistemology that would address the power issues of vested interest inherent to these concerns. The critical approach of discourse analysis offered productive possibilities to explore the polemic produced by these diverse and contrary positions. In particular, Foucauldian notions about technologies of power appeared a useful approach to examine the question of how power is exercised (Foucault, 1983b).

Potter (1996) advises would-be discourse analysts not to match up a traditionally framed research question with a discourse analytical approach: indeed he suggests that starting with a specific hypothesis can hamper the whole approach. This study has therefore remained unconstrained by a formal research question and simply foregrounds the discourses that have constructed the nurse practitioner role within a New Zealand social and political context. The aim of the analysis was to

consider how power has been exercised to produce a particular nursing identity that is different from conventional nursing representations.

The theoretical approach chosen for the study employs a postmodern epistemology that questions taken-for-granted assumptions about the nature of truth as well as the way in which the modern subject is constituted. Foucault argued that the subject is constantly reconstituted by discourse having no fixed identity. Significantly, power and knowledge are interconnected with discourse, ordering reality in particular ways to produce the objects of which they speak (Foucault, 1989). That is, discourse both limits and creates possibilities for how something can be understood, as it is only possible to speak of particular discursive practices within particular knowledge domains (Foucault, 1991c). The connection of discourse to post-structuralist ideas about language leads to a focus on texts as representative of reality (Agger, 1991).

Operationalising Foucault's theoretical ideas into a method of discourse analysis has entailed the adoption of a plural approach of both textuality and discursivity to guide the analysis in this study. Texts that illustrate particular discursive positions have been selected for analysis from published literature and from the transcripts of interviews conducted with individuals who have been influential in the unfolding of the nurse practitioner role in New Zealand. Eschewing expectations of conventional positivist research methodology (Angen, 2000) and consistent with the epistemology of a postmodern/post-structural approach, literature reviewed for this study is threaded throughout the thesis and is treated as data, informing the analysis chapters presented in parts two and three of the thesis. These parts are entitled *Creating an Interstice* and *Practising in the Interstice* and refer firstly to the political discourses that have represented nurses and nursing, creating a space for advanced nursing practice in New Zealand; and secondly how nurse practitioners are represented as they practice from that space. The context of the health and disability sector from which the nurse practitioner role emerged is outlined next.

The health and disability sector in New Zealand

The present-day composition of the health and disability sector in New Zealand has its origins in the political ideology of welfarism in which universal access to free health and hospital care is considered to be a basic right and expectation of citizenship. A centrally funded public hospital system of secondary and tertiary level care is the mainstay provider of acute and elective health care services in this country, and in 2006, employed 54 percent of the 44,442 nurses holding practising certificates (M. Clark, 2006). Private specialist and hospital care is available, supported by a flourishing health insurance industry, and employs 9 percent of the nursing workforce (M. Clark, 2006). Under the New Zealand Public Health and Disability Act, 2000, administrative responsibility for public health services was devolved from central government to twenty-one District Health Boards (DHBs). The Boards each receive population-based funding for the provision of health and disability services inclusive of primary and secondary/tertiary level care. The contractual arrangements between the Ministry of Health (MOH) and DHBs are guided by the objectives of the New Zealand Health Strategy (Ministry of Health, 2001a), which was designed to provide a trustworthy and accessible service and reduce inequalities between the health status of Maori and Pacific peoples and other New Zealanders.

However, for historical reasons, primary care services are not entirely free to New Zealanders. Subsequent to the Social Security Act, 1938, a dual public/private system has existed in which general practitioners (GPs) secured the right to charge patients a co-payment in addition to the receipt of a state-paid subsidy. Primary care services and state initiated reform of the sector under the Primary Health Care (PHC) Strategy (Ministry of Health, 2001b) has been an important driver for the nurse practitioner role in New Zealand and forms the background context for the thesis. The role has potential to deliver trustworthy, accessible and equitable services promised in the New Zealand Health Strategy (2001). The entry of a primary health care discourse into New Zealand health politics is explored in the following section, and more detail about the political discourses that shape the health sector can be found in chapter four.

Primary health care

Concerns over escalating health care costs in the 1970s led to a flurry of interest by governments around the world in the broad concepts of primary health care and health promotion recommended in the Alma Ata Declaration in 1978 and the Ottawa Charter in 1986. In New Zealand communities, family doctors or general practitioners were assumed to be the logical leaders in the implementation of the new concepts of primary health care, but in reality they continued to service their patients only when called upon for sickness. In rural areas, general practitioners were extremely overworked, and a government incentive scheme (the practice nurse subsidy) was introduced in 1970 to encourage doctors to employ nurses who could relieve them of the more mundane aspects of general practice work. The scheme soon spread to urban areas, but as employees of doctors who largely controlled their activities, practice nurses were often assigned "minor medical tasks, receptionist's duties and tea-making" instead of "capitalising on their people skills to run effective health preventative programmes" (Listener, 2001, p. 38). Thus the understanding of primary care as primary *medical* care has persisted, effectively marginalising community development and health promotion (Carryer, Dignam, Hughes, Horsborough, & Martin, 1999), as well as nursing initiatives in these areas.

Historically, general practitioners were paid a co-payment from the patient for each visit. In addition they received a government subsidy (the general medical subsidy or GMS) for patient consultations only and not for health promotion and education that addressed local community need. The health reforms of the 1990s began to address the lack of accountability for health outcomes for the millions of dollars being paid in GP subsidies, but the PHC Strategy (2001b) was the first government document to seriously enact policy related to primary health care and attempt to address health disparities so evident in mortality statistics (Crampton, Salmond, Blakely, & Howden-Chapman, 2000).

Funded by DHBs, the PHC Strategy made provision for the establishment of community trusts called Primary Health Organisations (PHOs). Although it was intended that PHOs would share governance responsibility amongst a range of health practitioners and consumers, many continue to assume medical leadership

of primary health care via the GP-led model of small business ownership. Further frustrating the intent of the PHC Strategy, population-based primary health care seems to be viewed by some medical practitioners as an imposition on practice that increases costs without increasing revenues (Crampton, Davis, & Lay-Yee, 2005). What is more, as Stephen Peckham (1999, p. 209) suggests, "the participation and collaboration with local populations and other primary care providers [necessary to a public health approach is] an area where physicians have little experience". Nurses however, are educationally prepared for primary health care (Carryer et al., 1999) and aware "to a far greater degree than doctors of the social and environmental factors that impinge on health" (C. Brown & Seddon, 1996, p. 34). Not surprisingly, nurses are described as "crucial to the implementation of the [PHC] Strategy" (Ministry of Health, 2001b, p. 23). A primary health care discourse has, therefore, created a space that nurses working in primary care can appropriate.

Even a cursory review of the New Zealand literature about nurse practitioners reveals a theme of medical resistance to the role. Those practitioners exhibiting the most resistance are located not in the secondary/tertiary sector, where there has been some considerable support (for example, in neonatology at Waikato Hospital), but the primary sector where traditional areas of jurisdiction are felt to be threatened by a potential business competitor. It is important to emphasise that the role of the medical or general practitioner in the provision of medical care is not in dispute in this thesis. What is challenged is the persistent and insistent theme of medical surveillance and control of nurses' practice and nursing issues. Primary care physicians, or at least the professional organisations representing them, have been vociferous in their defense of the general practice 'market', partly to preserve the family-doctor livelihood, and partly because assessment, diagnostic and prescribing skills now made available to nurse practitioners have hitherto been conceivable only within a medical discourse. These themes and others are threaded through the international literature about advanced nursing practice, and are briefly explored next.

International developments in advanced nursing practice

Although this thesis is concerned with the development of a nurse practitioner role for *New Zealand*, this section is intended to provide a sense of the international move towards advanced nursing practice roles, the supporting research, and the difficulties encountered in role implementation. Nurse practitioners have existed in the United States (US) since 1965 (Ford, 1997), and Canada since the 1970s (Canadian Nurses Association, 2005), escalating in numbers during periods of physician shortage. There has been a proliferation of advanced nursing roles in the United Kingdom (UK) since the 1990s (Daly & Carnwell, 2003), and in Australia, the first two nurse practitioners were authorised in December 2000 (G. Gardner, Carryer, Dunn, & Gardner, 2004). New Zealand has developed a model that draws on the experience of other countries (described shortly), and the first nurse practitioner was registered here by the Nursing Council in December 2001.

Internationally there is considerable diversity between countries in nurse practitioner scope, regulation, education, and title protection, as well as between provinces, states and territories. For example, a legislative update is published each year in the United States to describe the variation between states for nurse practitioners in title protection, requirement for medical supervision, legal authority, reimbursement, and prescriptive authority (Phillips, 2006). With the exception of the United Kingdom, the level of educational preparation for nurse practitioners is trending towards a master's degree (G. Gardner, Gardner, & Proctor, 2004), and in the United States, towards a doctorate of nursing practice (Hathaway, 2006). Diagnostic and prescriptive authority (with various levels of independence) is common to the US, Canada, UK, Australia and now New Zealand. International Council of Nurses consultant Fadwa Affara (2006) outlines the weaknesses that have arisen from such variation: poor role clarification, the proliferation of advanced nursing titles, mistrust in nursing between nurse practitioners and other nurses, a scope of practice that conflicts with other health professionals, inappropriate reimbursement, and varied levels of autonomy.

In spite of the variability between countries, there is a strong body of international research evidence concerning: the effectiveness of nurse practitioners (for

example, Feldman, Ventura, & Crosby, 1987; M. E. Jones & Clark, 1997; Shum et al., 2000; Spitzer et al., 1974); the cost-effectiveness of nurse practitioners (Shiell, Kenny, & Farnworth, 1993) or cost-equivalence to doctors (Venning, Durie, Roland, Roberts, & Leese, 2000); increased access to health care (M. E. Jones & Clark, 1997); nurse practitioner efficacy when compared to medical practitioners (for example, Bissinger, Allred, Arford, & Bellig, 1997; S. Brown & Grimes, 1995; Fall et al., 1997; Horrocks, Anderson, & Salisbury, 2002; Kinnersley et al., 2000; Mundinger et al., 2000; Shamian, 1997). Importantly, there is no international evidence to suggest nurse practitioners are not safe.

This body of literature is called 'defensive research' (Ford, 1997), designed to 'prove' the safety of nurse practitioners (F. Hughes, Clarke, Sampson, Fairman, & Sullivan-Marx, 2003) against "the 'mean' of the dominant paradigm of medicine" (Fairman, 2003, p. 59). In a review of the research in support of nurse practitioners spanning over forty years, Hughes at al. suggest a number of reasons for this self-conscious approach to inquiry: the assumption of physician competence; a competitive environment due to newly shared knowledge and skills; and physician-generated publications questioning nurse practitioner ability but supporting the physician assistant role. That said, this same body of research documents the power of nurse practitioner practice, a point well heeded by the American Medical Association, who have couched their resistance to expanded roles for 'non-physicians' in terms of patient safety and public protection, a claim based on medicine's higher claim to expertise (Fairman, 2003; see also American Medical Association, 2004). These same arguments have surfaced in the New Zealand medical community in spite of rigorous Nursing Council registration processes for nurse practitioners, and these are described next.

The Nursing Council of New Zealand and scopes of practice

The omnibus legislation governing the registration of health practitioners in New Zealand is the HPCA Act, 2003. The Act requires registration authorities such as the Medical Council of New Zealand or Nursing Council to define scopes of practice and the competencies and qualifications required to practise within those scopes. These descriptions form the legal space from which health practitioners can practice, while at the same time determining the boundaries for practice.

The HPCA Act, 2003 requires an authority (the Nursing Council) to publish in the government *Gazette* a description of the contents of the profession in terms of one or more scopes of practice and the prescribed qualifications. Prior to the implementation of the HPCA Act, and following an extensive consultation process, the Nursing Council elected four scopes of practice with the following titles: registered nurse, nurse practitioner, enrolled nurse and nurse assistant. Enrolled nurses and nurse assistants are second-level nurses and are not addressed in this study. The *Gazette* notices for the registered nurse and nurse practitioner scopes are reproduced below and are placed side by side for ease of comparison:

1. Scope of Practice - Registered Nurse

Registered Nurses utilise nursing knowledge and complex nursing judgement to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct Enrolled Nurses and Nurse Assistants. They provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills. This occurs in a range of settings in partnership with individuals, families, whanau[1] and communities. Registered Nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered Nurses may also use this expertise to manage, teach, evaluate and research nursing practice. There will be conditions placed on the scope of practice of some Registered Nurses according to their qualifications or experience limiting them to a specific area of practice.

2. Scope of Practice - Nurse Practitioner

Nurse Practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to 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, and in local and national policy development (NZ Nursing Council, 2004, September 15).

[1] Māori term for family

The registered nurse scope stresses the broad range of settings and function available to nurses, describing 'a range of settings', a 'variety of clinical contexts', performing 'general nursing functions' and 'comprehensive nursing assessments'. This is in contrast to the nurse practitioner scope which twice stipulates the expertise associated with this role is confined to a 'specific area of practice'. A self-imposed mechanism of limitation of practice occurs as a result of a nurse practitioner defining the area of practice specialty. For example, if a NP nominates the specialty area of 'wound care', they may use diagnostic and prescribing skills only in relation to wound care, and not, for example, for a cardiac-related condition. Areas of specialty particularly contentious for general practitioners have been the more broad descriptions, for example, 'primary health care across the lifespan' (Boswell, 2005a).

Both the registered nurse and nurse practitioner scopes contain the same phrase describing practice as occurring 'independently and in collaboration with other health professionals': thus, all nurses (except enrolled nurses and nurse assistants) are legitimately autonomous practitioners, free of the *requirement* to collaborate with other professionals. Where collaboration *is* required is in the partnership with 'individuals, families, whanau and communities' and positions these people as central to the nursing endeavour.

Registered nurses may elect to move into management, nursing education or research without maintaining direct clinical contact, but the expectation expressed in the scope description is that nurse practitioners are leaders in all these areas, including professional activities and policy development, concurrently retaining a direct clinical focus of perhaps forty to fifty percent of their time (Harris, Smith, & Betts, 2003). However, what specifically differentiates nurse practitioner practice from registered nurse practice is the authority to make differential diagnoses, order and interpret diagnostic and laboratory tests, and prescribe medicines within a specific area of practice.

The qualifications required of registered nurses and nurse practitioners are specified in the Nursing Council *Gazette* notice as follows:

RN Qualifications

New Zealand Graduates

a) A Bachelor degree in nursing (or an equivalent qualification) approved by the Nursing Council of New Zealand, AND

b) A pass in an assessment of Nursing Council Competencies for Registered Nurses by an approved provider, AND

c) A pass in an Examination for Registered Nurses.

Registered Nurses from Overseas

a) Registration with an overseas regulatory authority, AND

b) An equivalent international qualification, OR

c) A pass in an assessment of the Nursing Council Competencies for Registered Nurses by an approved provider, AND/OR

d) Successful completion of a programme approved by Nursing Council for the purpose of assessing Competencies for Registered Nurses.

NP Qualifications

a) Registration with the Nursing Council of New Zealand in the Registered Nurse Scope of Practice, AND

b) A minimum of four years of experience in a specific area of practice, AND

c) Successful completion of a clinically focused Masters Degree programme approved by the Nursing Council of New Zealand, or equivalent qualification, AND

d) A pass in a Nursing Council assessment of Nurse Practitioner competencies and criteria.

Nurse Practitioners seeking registration with prescribing rights are required to have an additional qualification:

e) Successful completion of an approved prescribing component of the clinically-focused Masters' programme relevant to their specific area of practice (NZ Nursing Council, 2004, September 15).

Entry to the register of nurses requires a Bachelor of Nursing (BN), an assessment as competent in relation to the Nursing Council competencies, and a pass in the state nursing examinations. This is the pre-requisite qualification for a nurse practitioner, who must be a registered nurse with a minimum of four years specialty experience, have a clinical masters degree or equivalent, and be assessed by a Nursing Council panel as meeting the nurse practitioner competencies.

The rigor of the application process has led to more than half of the applications to the Nursing Council for nurse practitioner registration to be unsuccessful ("NP hurdle too high?," 2006). At the time of writing, there are thirty nurse practitioners registered with the Nursing Council of New Zealand, twelve of whom are able to prescribe medications within their scope of practice (Cassie, 2007). Although the Nursing Council describes both registered nurses and nurse practitioners as independent practitioners, autonomy and nurse practitioner practice has been a contentious issue for physicians.

Nursing autonomy

A chain or a thread that connects together questions of politics and professional ethics (Foucault, 2004) throughout the thesis is that of nursing autonomy. Mary Chiarella (1998) reflects on the necessity of having to make a statement about nursing autonomy and independence, and suggests that these words entered nursing discourse because the independence of nursing was restricted. Nursing autonomy was once restricted by the requirement to provide nursing services under the auspices of medicine and a hierarchical system of task delegation. No legal impediment served to restrict nursing autonomy in New Zealand[2]; rather, nurses as women were socialised into a subservient position to medicine in a world directed by men and were exploited as a useful and docile workforce easily controlled by the requirements of medicine and the health service. Aside from the access of women to the necessary education (a topic well beyond the scope of this study), in real terms, all that was missing from nursing autonomy a century ago were the tools of diagnosis and prescribing authority, and it is *the practices arising from the use of these tools* that have differentiated the practice of medicine from nursing all this time. The medical profession have been at pains to normalise this difference, knowing that "central to professional autonomy is power over diagnosis" (Porter, 1992, p. 723).

Foucault argued that the subject (that is, the individual) was not free and autonomous but always positioned in relation to particular discourses (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984). One is not, therefore, free to choose to be an autonomous practitioner; rather one is constructed as autonomous by the practices of education and legislative sanction and by society (Baer, 2003). In the Nursing Council scopes' description of *both* registered nurse and nurse practitioner practice, nurses are legislatively sanctioned to be autonomous practitioners. However, the degree to which a practitioner chooses to exercise autonomy is one of personal choice (Ballou, 1998), and for Foucault, is encompassed within "a broad set of personalized ethical practices that construct relationships to oneself, to authority, and to truth" (Luxon, 2004, p. 465). Contrary to arguments opposed to nurse practitioner autonomy, this new role does not

[2] An exception is the Nurses Act, 1971 which removed the autonomy of midwives.

concern the acquisition of *more* autonomy, but the free exercise of power already present (Fairman, 2003).

In many respects, this study is a sequel to Elaine Papps' PhD thesis (1997) in which she critically analysed the discourses constructing the New Zealand registered nurse identity. Like this study, her work was informed by the work of Foucault. The difference is that her study suggested medicine is the dominant discourse of nursing (Papps, 1997), while this study suggests that *nursing* is the dominant discourse of the nurse practitioner. This shift arises from a different subjectivity, paradoxically created for nurse practitioners through practices traditional to a medical discourse being embraced within a nursing discourse. In a later publication, Papps (2001, p. 4) advises readers to watch the space created for nurses by the nurse practitioner concept, because "it represents an opportunity for nurses to imagine what might be".

The structure of the thesis

This thesis is structured in three parts. Further detail about the content and theoretical tools employed in each section is outlined separately at the beginning of each section. Part one of the thesis comprises three chapters that set the scene for the study by introducing the study (chapter one), explaining the theoretical concepts used (chapter two), and the methodological approach and tools employed (chapter three). A deliberate choice was made to position the key theoretical underpinnings of postmodernism, post-structuralism and the work of Foucault as the means to review and critically interrogate the published literature threaded throughout the thesis.

Part two of the thesis is entitled *Creating an Interstice* and elaborates on the discourses that are background to a nurse practitioner role emerging in New Zealand. These chapters comprise a genealogy of a radical shift in perspective of how nursing is represented. The political discourses that are outside nursing but have nevertheless positioned nurses in the health sector are examined in chapter four. Chapter five considers the discourses internal to nursing that have represented nurses and nursing both professionally and industrially dating back to the Nurses Registration Act, 1901. Chapter six examines the construction of the

registered nurse as competent in relation to academic and regulatory discourses and it highlights how notions of competence led to notions of nursing 'expertise'. The last chapter in this part of the thesis concentrates on the Ministerial Taskforce on Nursing in 1998 and traces the struggle within nursing for power to control the future of advanced nursing practice. It arrives at a final construction of the *most* expert nurse, the nurse practitioner, within a state-sponsored regulatory framework.

Part three also comprises four chapters and is entitled *Practising in the Interstices.* It analyses the discourses both constraining and providing opportunities for nurse practitioner development in the 21st century. Specifically, chapter eight examines the business model of general practitioner proprietorship that constrains the expansion of nursing practice into nurse practitioner roles, despite the context of a new government regime introduced with the PHC Strategy (Ministry of Health, 2001b). Chapter nine examines medical resistance to the introduction of prescriptive privileges for nurse practitioners and the protracted journey of negotiations that brought about legislative change. Chapter ten foregrounds the representations of existing New Zealand nurse practitioners as a new and more liberating mode of subjectivity, one defined by a *nursing* discourse and *nursing* practices informed by multiple forms of knowledge, only one of which is medicine. Chapter eleven concludes the thesis by drawing together the main arguments presented throughout parts two and three, mentioning the limitations of the study and listing implications for further research. Finally, recommendations are offered that are directed at challenging what *is* (Foucault, 1991d) and reinforcing what nursing has become.

Chapter 2: Theoretical Expanse

Introduction

The theoretical foundations of this study are informed by the work of French philosopher and historian, Michel Foucault (1926-1984). Informing the analysis of the nurse practitioner role in New Zealand, the ideas presented are not a complete summary of his work, but a précis of the main theoretical ideas used in the thesis. A central premise of a postmodern epistemology addressed in this chapter is to question taken-for-granted assumptions about the nature of truth, linking knowledge production inextricably to power (Lyotard, 1984). Power becomes central to the way in which the modern subject is constituted, and discourse is the means by which power circulates. Foucault used a historical technique he called 'genealogy' to examine the interconnections between discourse, knowledge and power, and the production of the subject. By so doing, he challenged humanist conceptions of the individual and dispensed with the constituent subject. With no fixed identity, subjectivity is constantly reconstituted in discourse (Weedon, 1987). The connection of discourse to post-structuralist ideas about language leads to a focus on texts and the ways language is involved in the construction of the 'other'.

A discussion of these ideas follows, including the way in which human beings are made both object and subject through disciplinary techniques and techniques of the self. The art of government – expressed by Foucault as governmentality – concerns the way in which the population, as well as health practitioners, are made subject to regimes of truth and adapt their conduct accordingly. Examples of how Foucault's work has been used to explore the nurse practitioner role are included throughout. The next chapter on methodology is partner to this theoretical discussion and contains a description of the approach to discourse analysis used in this study.

A postmodern and post-structural epistemology

The choice of a postmodern epistemology for this study arose from a desire not to capture the 'absolute' truth but to offer an interpretation or version of the truth that will inevitably be partial (Wetherell, Taylor, & Yates, 2001a). A postmodern epistemology validates human experience, emphasising that there are "multiple positions from which it is possible to view any aspect of reality" (Cheek, 2000, p. 20). This position does not desire to speak 'for' others; rather, it ensures that various points of view are heard with none privileged above others (Cheek, 2000). In this context, the 'truth' cannot be represented as a single reality but exists as the possibility for multiple realities and therefore, truths. Representative of the nature of the world itself, the possibility for multiple truths reflects the ontological position of this study (Wetherell et al., 2001a).

Assuming a postmodern position is not without its problems and has been the topic of much philosophical (and political, sociological, artistic and ethical) debate. The nomenclature of 'postmodern' suggests that this set of ideas emerged subsequent to 'modern' thinking. The modern era is associated with the European Enlightenment, beginning approximately in the middle of the eighteenth century and defined in relation to Antiquity (Mann, 1996; Sarup, 1993). Sarup (1993) suggests that the postmodern era began after the Second World War, due to vast changes in the nature of Western society. There is difficulty determining when – and if – modernity was supplanted by postmodernism because modern ideals remain current today. Habermas in particular was not convinced of a distinction between the two, suggesting that postmodernism developed *within* the larger, still current modern framework (Kelly, 1994). Another view is that because the world is not made of binary oppositions (Winterson, 1996), postmodernism is a continuum rather than a distinct break from modernity (Sarup, 1993).

Modernity itself has been variously defined but is usually considered to be "positivistic, technocratic and rationalistic", with an emphasis on the linear nature of progress, the standardisation of knowledge and truth, justice, and the "possibility of happiness for all human beings" (Sarup, 1996, p. 94). Modernity strives to maintain stability, rationality and order, asserting the superiority of

order by constructing binary oppositions between order and disorder (Mann, 1996). Postmodernism, on the other hand, is broadly considered to reject modern constructs of the "progressive liberation of humanity through science, and the idea that philosophy can … develop universally valid knowledge" (Sarup, 1993, p.132). These themes are examples of legitimising myths of the modern age, known as 'grand narratives' or 'metanarratives'.

Writers such as Foucault and Lyotard challenged large-scale 'totalising' discourses said to apply universally. In *The Postmodern Condition,* Lyotard (1984) sees scientific knowledge as existing in addition to, but in competition and conflict with 'narrative' knowledge, which is knowledge that is contextualised and local. Science is merely a subset of what is known and cannot be equated with *all* knowledge, as modernity tends to suggest. In contrast to scientific knowledge, narrative knowledge is not subject to a challenge of legitimacy on the same terms as science, which requires a "discourse of legitimation" (p. xxiii) to verify and falsify its truth finds. Consequently, narrative knowledge from a scientific perspective is "not knowledge at all" (p. 29).

In questioning the authenticity of *science*, Lyotard (1984) suggests any attempt at legitimacy raises both socio-political and epistemological implications – particularly as knowledge is inextricably linked to power. The link between knowledge and power is further linked to imperialism, government and commercial interests. Lyotard asks: "who decides what knowledge is, and who knows what needs to be decided?" (p. 9). The postmodern position, then, is a challenge to the metanarrative of science as the sole teller of truth; it is one of "incredulity toward metanarratives" (p. xxiv).

Although often used synonymously with postmodernism, post-structural perspectives refer more specifically to a theory of knowledge and language (Agger, 1991; Cheek, 2000). In contrast to modern thinking, language in post-structuralism is not considered to be objective and does not convey reality in a value-free way. The emphasis on language leads to a focus on texts as representative of reality. It is the discourses, the "practices and assumptions that underpin the shaping of the text itself," that are "as much interest as what the text actually describes" (Cheek, 2000, p. 40). An enquiry into the background

practices and assumptions of a collection of texts is known as discourse analysis. It is one method that can be adopted within a post-structural approach (Cheek, 2000), and it is the principal method of enquiry adopted in this study.

In company with discourse analysis and post-structural approaches is a method made popular by French Algerian philosopher Jacques Derrida (1976), known as deconstruction (although Derrida, like Foucault, did not identify his work as post-structural, nor did he reduce deconstruction to a method). Concerned with the interrogation of texts, deconstruction searches out contradictions in language to challenge the assumptions on which meaning is founded (Cheek, 2000). The purpose is not to find 'the' meaning (or truth) in a text, but to reveal the subtext within a text, which in turn becomes a new text as it is read and is subject to its own deconstruction (Agger, 1991). A deconstructive approach has value in the research process as it has the potential to render visible the taken-for-granted beliefs that are central to health practice.

Language, like discourse, is more than a technical device for communicating stable meanings, but is a profoundly constitutive act (Agger, 1991). Western logocentric knowledge "produces dichotomies of 'presence' and 'alterity' (otherness) that, upon deconstruction, are revealed to be hierarchies that reduce alterity to negative mirror images of presence" (Agger, 1994, p. 501-502). Despite the many challenges to dichotomous thinking, Western culture is argued by many to be dominated by dualistic thinking. Adhering to a 'top-down' or hegemonic conception of power contrary to a Foucauldian technique of analysis (discussed in the remainder of the chapter) the relevance of binary oppositions to this study lies in the following crucial point:

> … one group of concepts in the dualist system has been consistently positively valued in modern Western culture. These concepts have been presented as self-evident, neutral descriptions of the world, but have carried hidden social and political values that have been instrumental in creating devalued 'others' (Lines, 2001, p. 173).

The notion of 'otherness' is used theoretically in the thesis to explore, for example, the persistent definition of nurse practitioner in relation to medicine that

serves to perpetuate the hierarchical binary of doctor/nurse. Deconstruction endeavours to question the priority of things that are seen to be natural or self-evident. Simply reversing the hierarchy often serves no valuable purpose other than to say the second is now better than the first. To deconstruct a hierarchy in a useful way is to valorise and give voice to alterity and to favour the 'small narratives' overlooked in the master narratives of modernity (Agger, 1994).

The postmodern and post-structuralist position of this thesis was chosen to question the assumptions embedded in modern thought. The argumentative texture of competing discourses surrounding the success or demise of nurse practitioners in New Zealand creates a discursive space (Wetherell, Taylor, & Yates, 2001b) that presents possibilities for deconstruction. What is more, a postmodern approach presents useful possibilities for questioning traditional thinking about nursing and how these views have shaped the emergence of an advanced nursing role: the nurse practitioner.

The next sections explore the central themes of the work of French philosopher Michel Foucault, which are used to inform the analysis of the texts chosen for this study. The ideas presented should not be considered a complete overview of his work because they are confined entirely to the theoretical concepts used as tools to aid analysis in parts two and three of the thesis.

Genealogy

Foucault was profoundly influenced by the writings of Nietzsche (Foucault, 1977b), who was skeptical of both language and 'truth' because of their propensity to adopt a fixed perspective toward things. In Nietzsche's view, language is a seduction, expressing a world of rigid facts that create a conception of truth and absolutes about such things as God and morality. He was similarly skeptical of the existence of subjects able to "choose or not choose to act in certain ways" (Mansfield, 2000, p. 57).

Nietzsche's theoretical thinking about the subject informed Foucault's concept of genealogy, an expansion of his earlier method of archaeology[3]. Both methods are concerned with history, although not in terms of the traditional historical research associated with modernity. Rather, archaeology and genealogy seek to produce a history of discourse, but genealogy brings the focus back to the human subject (A. Allen, 2000). Unlike Nietzsche's ideas, however, genealogy emphasises "*power* rather than knowledge, and *practices* rather than language" (Olssen, 2003, p. 194). Genealogy, therefore, has a specific interest in the 'self' as it is policed by systems of knowledge and power. These ideas led to Foucault's works on penal institutions and sexuality.

Foucault's theorising on the subject as a construct emerged from his rejection of phenomenological philosophers (such as Husserl and Merleau-Ponty) who worked from a belief in the constituent subject:

> I don't believe the problem can be solved by historicising the subject as posited by the phenomenologists, fabricating a subject that evolves through the course of history. One has to dispense with the constituent subject, to get rid of the subject itself, that's to say, to arrive at an analysis which can account for the constitution of the subject within a historical framework. And this is what I would call genealogy, that is a form of history which can account for the constitution of knowledges, discourses, domains of objects etc., without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history (Foucault, 1980a, p. 117).

Genealogy is, then, a methodology concerned with how the subject is constituted by history, by cultural practice, by language, by institutions, by knowledge, and by power – all of which make up particular discursive fields. Such an analysis extends even to the function of the author of published works, whose subjectivity also is constituted by discourse, and this in turn contributes to discourse by the very act of writing (Foucault, 1977c). As author of this thesis I present my own

[3] Foucault used the term 'archaeology' to refer to the discursive production of knowledge in different historical periods (Danaher, Schirato, & Webb, 2000).

reading of history, a new reading shaped by the discourses that constitute my subjectivity; most obviously – but not exclusively – by nursing and academic discourses. As a contribution to nursing discourse, this project uncovers aspects of what traditional historical knowledge hides, revealing the basis of the modern nursing subject.

In his essay *Neitzsche, Genealogy, History,* Foucault (1977b) suggested the role of genealogy was to find not the beginning, but "numberless beginnings" (p. 145). Similarly, its role is not to find a unified story but a multiplicity of stories. The process involves recording the history of morals, ideals and metaphysical[4] concepts in such a way that they become historically noteworthy. In genealogical terms, significant historical events are marked by shifts, where there is a "reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once used it…" (Foucault, 1977b, p. 154). The genealogical approach marks a shift from Hegelian concepts of the total truth that reach an end point, to the notion that history is never really over. Rather, the present is 'birthed' by the past in an historical ontology.

As such, the role of the nurse practitioner has been 'birthed' by the past, by a history that records events in the traditional sense, but also by a reading that reveals the discourses and interconnections between power and knowledge. My reading includes the ways in which discourses are supported "institutionally, professionally, socially, legally and economically" (Carabine, 2001, p. 276), involving the writing of a history that reveals the struggles, discontinuities and the role of the individual. Foucault's genealogical method examined the triad of discourse, knowledge and power explained further in the next section.

Discourse/Knowledge/Power

Foucault's understanding of discourse was linked in an interconnected triad with power and knowledge. Problematising knowledge as neither objective or value-free, he explored the link between knowledge and power using the concept of discourse (Cheek, 2000). Knowledge produced by the human or social sciences serves to establish the norm, and generates a set of assumptions that creates 'what

[4] Metaphysics is the branch of philosophy that deals with being and knowing (Hanks, 1981).

is known' and what is construed as 'truth' (Wetherell et al., 2001a). The perceived authority that a discourse carries orders reality in a particular way that may either enable or constrain an individual by privileging certain ways of thinking over others (Cheek, 2000). As such, discourse is no longer simply a system of signification, but practices that produce the objects of which they speak (Foucault, 1989). Thus, for Foucault, discourses are bodies of knowledge constituted by power to determine possible subject positions: they are imbued with power and "power produces; it produces reality; it produces domains of objects and rituals of truth" (Foucault, 1977a, p. 194).

Truth, therefore, is the winning set of discursive practices at any given moment, and power is a strategy or a game not consciously played by individuals, but one that operates within the machine of society. There is a desire for, or will to truth (Foucault, 1977b) such that:

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

What counts as true circulates through mechanisms of education under the control of institutions such as the university, the army, and the media (Foucault, 1980a). An example of the status of those charged with delivering the truth is of the doctor, who is qualified according to statute as competent based on a diverse range of knowledge acquired through various institutional sites such as the university, the laboratory, the library, and the hospital; who is entrusted by society to intervene and make decisions about different cases, claiming even, "the power to overcome suffering and death" (Foucault, 1989, p. 51). The status of medical discourse from which a doctor speaks is connected to power because it determines possible subject positions for members of society and, as concerns the topic of this thesis, for nurses. However, Foucault considered the human sciences (and in particular medicine – see Foucault, 1989) to be dubious disciplines, "which in

spite of their orthodoxies show no sign of becoming normal sciences" (Dreyfus & Rabinow, 1983, p. 120). Danaher et al. (2000, p. 26) explain further:

> Foucault argued that the knowledge and truth produced by the human sciences was, on one level, tied to power because of the way in which it was used to regulate and normalise individuals. ... The state drafts policies and laws that determine legally who is normal and healthy, and who is morally or physically perverted and dangerous. However, these policies and laws are based on the knowledge produced by disciplines and institutions. In other words, knowledge, in a sense, authorises and legitimates the exercising of power.

Illustrating Foucault's multidimensional concept of power, the discourses of truth that have taken charge of nursing through the dictates of power have created a binary of things nurses are permitted to do, and things they are forbidden. The power to define boundaries becomes law not because of legislature, but because the very act of discourse constructs the rules. The practice of nurses is therefore curtailed (or otherwise) by the way nursing is represented in language, being articulated in the everyday practices of the provision of health care, but also in the publication of documents that circulate particular views. The function of legislation as 'pure' power is but one of a number of tactics and is highly visible. The success of these other techniques is "proportional to its ability to hide its own mechanisms" (Foucault, 1990, p. 86).

Critiquing the 'juridico-discursive' or sovereign concept of power, where law is equated with power, Foucault rejected any position which maintained that power is unilaterally exercised in order to dominate and subjugate. Rather than functioning only on the basis of law, Foucault proposed that power is deployed in techniques of discipline and normalisation, embracing everything and everybody (Rabinow & Rose, 2003). Foucault's position on power can be summarised thus: (1) power is not a thing to be acquired or lost; (2) power is not external to relationships (such as economics, knowledge or sex), but internal, and determines their structure. Furthermore, power relationships "have a directly productive role, wherever they come into play" (Foucault, 1990, p. 95); (3) power is not associated with a binary of top to bottom; (4) there is often no 'inventor' or plan to the logic

and aims in the exercise of power; and (5) where there is power there is always resistance. That is, there are multiple mobile and transitory points of resistance present everywhere in the power network that emerge in different places as the dynamics of power change.

To summarise, Foucault used the interconnected concepts of discourse, knowledge and power in order "to construct a mode of analysis of those cultural practices in our culture which have been instrumental in forming the modern individual as both object and subject" (Dreyfus & Rabinow, 1983, p. 120). The way Foucault understood the individual as object and as subject is explained in the following sections.

The individual as object

Foucault was interested in the way the subject was objectivised by the use of 'dividing practices': "the subject is either divided inside himself or divided from others. This process objectivizes him. Examples are the mad and the sane, the sick and healthy, the criminals and the 'good boys'" (Foucault, 1983b, p. 208). Within these divisions, groups are formed to produce particular deviant identities or subject positions against which a standard of normality can be measured (Danaher et al., 2000). Along with prisons, Foucault's theorising gives examples of institutions that are created by society to put people where they 'belong'; where they might behave in prescribed ways, such as hospitals, military barracks, monastic cells, and schools.

Dreyfus and Rabinow (1983) stress the originality of Foucault's work as he isolated "the specific mechanisms of technology through which power is actually articulated on the body" (p. 113) in "meticulous rituals of power" (p. 114). Where once power was put constantly and publicly on display and focused on the sovereign, disciplinary power turned these relations around to make power itself invisible and the objects of power – "those on whom it operates – are made the most visible" (Dreyfus & Rabinow, 1983, p. 159). Thus power is deployed through techniques of discipline, having effects on the body and relying principally on surveillance.

The body/the gaze

Foucault revealed how the rise of disciplinary power toward the end of the 18th century brought the body under constant surveillance. He explored the way medicine established expert power over the body in his text, *The Birth of the Clinic*, first published in 1963. For centuries, disease had been an unknowable mystery associated with many medieval superstitions. Then during the Enlightenment, a new era emerged initiated by a search for new knowledge and the pursuit of rational explanations defined in cause-and-effect terms. These scientific assumptions formed the basis of the medico-scientific gaze, and in combination with Descartes' theory of mind–body dualism, formed the basis for a primarily physical 'biomedical' approach to illness and disease (Samson, 1999).

The clinical gaze of a physician was the technique by which medicine came to have knowledge of bodies and to understand its mechanics. An improved knowledge of pathological anatomy (by cadaver dissection), as well as the developing practices of nosology[5], histology[6] and microscopy[7] turned "what was fundamentally invisible" and offered it "to the brightness of the gaze" (Foucault, 1994, p. 195). The most convenient place for the gaze to develop was the teaching hospital, which became a space that awarded medicine legitimate social power to view what had previously been private. The hospital or 'clinic' became an institution capable not only of practice and teaching but also discovery, changing it into a clinic of science (Foucault, 1994).

Embracing more than the word 'gaze' suggests, the medical gaze encompasses a trinity of sight, touch and hearing, which incorporate particular examination techniques into the physical assessment of a patient (for example, palpation, auscultation and percussion). Furthermore, according to Armstrong (1997), *'le regard'* is inadequately translated from the French into English as the gaze and fails to fully capture the subtlety of perception that is also implied. Constructed as perceptive, physicians are deemed to be wise, but more significantly perhaps, "the gaze that sees is the gaze that dominates" (Foucault, 1994, p. 39).

[5] Nosology – the branch of medicine concerned with the classification of diseases
[6] Histology – the microscopic study of cells and tissue
[7] Microscopy – the use of microscopes (definitions from Hanks, 1981).

Acquired through the practical observations made by the clinician, the gaze holds substantial power and produces medical knowledge that becomes the "authoritative 'truth' about the body and the person" (Samson, 1999, p. 153). By describing the body in detail, it became "possible to organise a rational language around it" and "one could at last hold a scientifically structured discourse about an individual" (Foucault, 1994, p. xiv). Taking on the status of object, knowledge of the body no longer resided with the owner of the body, but with the expert doctor. What is more, turning the body into an object of knowledge (Gastaldo, 1997) transformed the body into a docile object of power.

Disciplinary techniques

In the face of expert knowledge, a new power relationship was established between doctor and patient that overrode the experience of embodiment. The medico-scientific gaze achieved compliant and 'docile' patient bodies, but a 'micro-physics' of disciplinary power that made use of "meticulous, often minute, techniques … tended to cover the entire social body" (Foucault, 1977a, p. 139). The changing nature of surveillance is traced in *Discipline and Punish* as an account of the shift in Western cultural practices from the sovereign power of the monarchy to disciplinary power. Foucault marked the transition from a top-down form of social control in the form of physical coercion meted out by the sovereign, to a more diffuse and insidious form of social surveillance.

Disciplinary power aims to forge *docile* bodies that are also *useful* in both economic and political terms. This relation of docility-utility gives rise to a body which is both useful and productive, and is a concept used in chapter five to examine historical representations of the nursing workforce. Disciplinary power comprises three interrelated techniques: discipline, surveillance and punishment. Disciplinary techniques work to control and enhance efficiency by training the body in drilled performance, particularly of tasks. As objects, bodies would automatically and reflexively respond when instructed, as opposed to subjects, who might voice an opinion expecting to be heard. To be effective, disciplinary power must work as continuously as possible in all dimensions of space, time and motion (Dreyfus & Rabinow, 1983).

Although “discipline is a technique, not an institution” (Dreyfus & Rabinow, 1983, p. 153), techniques of surveillance are most easily achieved in institutions. They act as machines for transforming and controlling people using power techniques of rank, space, time, timetables, and exercise and produce the body as a cog in a machine (Foucault, 1977a). Combining the medico-scientific gaze with themes of surveillance and power, Foucault elaborated on the 18th century imaginary prison design of Jeremy Bentham and introduced the idea of the Panopticon. In this design, the prison cells were arranged around a central watchtower, enabling the prisoners to be watched at any time. Yet the prisoners could never be certain when they were being watched, and over time, began to police their own behaviour. In a “subtle calculated technology of subjection” (Foucault, 1977a, p. 221), the Panopticon was a machine for exercising continuous disciplinary power.

Although Foucault (1977a) specifically examined penal institutions, he maintained that generalised practices of disciplinary procedures extended to other sectors of the population also. He suggested the discipline of individuals can take place in many forms, but the architectural design of buildings is an example of how the organisation of space controls individuals by means of dividing and enclosing practices. The arrangement of partitions in grids in institutions such as hospitals, monasteries, schools, prisons, factories, or in the military, allows for the orderly distribution of individuals, who can then be readily supervised and compared to others. The blend of “architectural, functional and hierarchical” techniques not only “guarantees the obedience of individuals” but crucially links surveillance to economic function (Foucault, 1977a, p. 148). Hierarchical arrangements allow for the supervision of individuals who are not only ‘looked over’ themselves, but who ‘look over’ the actions of others, thereby maximising productivity and control at multiple levels of the institution. When hierarchical observation and normalising judgment combine, a central technique of disciplinary power arises: the examination (Dreyfus & Rabinow, 1983).

The examination is characterised by normalising judgment and micro-penalty. Dreyfus and Rabinow (1983, p. 158) describe normalising judgment as complex, suggesting it starts from an “an initial premise of formal equality among

individuals. This leads to an initial homogeneity from which the norm of conformity is drawn." More than a binary of good/bad, an individual strives to negotiate their position in relation to the norm, producing a discontinuous, uneven and contradictory process (Carabine, 2001). Non-conformity, however, becomes the focus of disciplinary attention in the form of micro-penalty. Examples Foucault gives of non-conforming behaviours are "of time (lateness, absences, interruptions of tasks), of activity (inattention, negligence, lack of zeal), of behaviour (impoliteness, disobedience), of speech (idle chatter, insolence), of the body ('incorrect' attitudes, irregular gestures, lack of cleanliness), of sexuality (impurity, indecency)" (Foucault, 1977a, p. 178). Punishment techniques may be subtle, ranging from "light physical punishment to minor deprivations and petty humiliations" (p. 178). They are also corrective and repetitively exercise an individual towards a desired behaviour. Furthermore, disciplinary techniques award privileges on the basis of 'good' performance and behaviour, "making it possible to attain higher ranks and places" (p. 181), and withholding privileges such as promotion when performance is judged to be 'bad'. Essential to the examination is knowledge acquired by establishing visibility over individuals and "through which one differentiates and judges them," assessing acts with precision, and judging individuals 'in truth' (p. 184).

Combining both power and knowledge, the examination serves to individualise all those subject to control and surveillance via a meticulous and highly ritualised mechanism of documentation that produces dossiers, each containing "minute observations" (Dreyfus & Rabinow, 1983, p. 189). The technology of the dossier is used in chapters five and six in relation to nurses' professional development portfolios. As dossiers, portfolios make each individual into a 'case' who is "described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded, etc" (Foucault, 1977a, p. 191). The description contained in the dossier becomes, therefore, "a means of control and a method of domination" (p. 191).

The category of the 'nurse'

An early task of the hospital was to separate dangerous types of bodies and prevent their mixing (Dreyfus & Rabinow, 1983). This was an important means to

prevent the spread of infectious disease, but people were also partitioned from one another on the basis of age, sex, and rank (in the case of soldiers), and social standing. The medical supervision of disease was more easily achieved within these defined therapeutic spaces (Foucault, 1977a).

The divisions within the hospital ensured the perpetual visibility and medical supervision of the sick, but had other consequences on the internal hierarchy as the continual presence of physicians relegated religious staff "to a clearly specified, but subordinate role in the technique of the examination; the category of the 'nurse' then appears" (Foucault, 1977a, p. 186). Thus, not only were patients subject to medical surveillance, but nursing work was also. As Foucault points out, "the 'well-disciplined' hospital became the physical counterpart of the medical 'discipline'" (Foucault, 1977a, p. 186), and it became the province of an emerging science of nursing to ensure the relationship to medicine continued.

'The means of correct training' of nurses for the task of maintaining a well-disciplined hospital made full use of the disciplinary techniques so far described. Similar in purpose to the training of military officers, the pedagogical intent of the hospital was to train suitable young women in such a way that peremptory particulars were met. Those particulars were to: "train vigorous bodies, the imperative of health; obtain competent [nurses], the imperative of qualification; create obedient [nurses], the imperative of politics; prevent debauchery and homosexuality, the imperative of morality" (Foucault, 1977a, p. 172). Each objective was achieved through techniques of domination applied to every aspect of a nurse's work and living conditions. They were supervised at every turn by either doctor or hospital matron. Nursing work was organised to align with medical needs and produced a nursing workforce shaped by both medical and gender discourses, represented as passive, docile, obedient and subservient (Papps, 1997, 2001). The role of nurse practitioner, however, operates beyond traditional techniques of medical surveillance and dominance, and counter to traditional representations of a nursing role. Furthermore, the space to create a new subjectivity emerges as nursing is liberated from the definitions and truth claims of others (Papps, 2001).

The individual as subject

Subjectivity may be usefully understood to refer to identity: it is a construct, an experience (Mansfield, 2000) or, more specifically, the "conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1987, p. 32). Foucault's main objective was to create a history of how human beings are made subjects (Foucault, 1983b; Rabinow & Rose, 2003). His conception of subjectivity rejected the notion of a free and autonomous individuality, preferring any such definition to concern subjectivity being "the product of culture and power" (Mansfield, 2000, p. 51). As a *construct,* subjectivity is made up of the effects of power and, at the same time, subjectivity is the vehicle for the exercise of power (Foucault, 1980b). Foucault's aim was to better understand *how* the subject was constituted precisely to avoid the assumption (since Descartes) of the subject *as* constituent. He therefore turned his "philosophical investigation on the concept of subjectivity itself" (A. Allen, 2000, p. 122).

A post-structural approach to subjectivity suggests that particular roles are not linked to specific individuals, but rather a person will take on a role that has been in existence for some time perhaps. In doing so, they enter "into the processes which regulate what occurs within the field, and their identity or subjectivity is shaped by the operations of that field" (Danaher et al., 2000, p. 33). It is discourse that determines the possibilities for the field, serving to produce the subject in particular ways. While all forms of subjectivity are theoretically open to an individual, an individual's access to particular subject positions is determined and often limited by historical social elements (Weedon, 1987). For example, because the traditional nurse's role is to follow the orders of a physician, a nurse practitioner who initiates his or her own treatment order adopts a new subjectivity foreign to existing nursing practice.

During a period of 'autocritique' in the mid 1970s, Foucault reconsidered his largely negative and repressive conception of power (Rabinow, 1997). He began to realise that:

> [w]hat makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1980a, p. 119).

Considering power as productive makes it possible to conceive of the subject as produced. Disciplinary practices as techniques of power may be thought of therefore, as not only producing objects, but also subjects:

> Individuals are *subject* to disciplinary power, which is exercised over them and subtly and insidiously constrains their choices, desires, and actions, and, at the same time, they are made *into subjects* by disciplinary power, which creates various subject-positions and incites individuals to take them up. In this way, power both enables the constitution of subjects and constrains the subject so constituted (A. Allen, 2000, p. 123).

Importantly, Foucault argued for the possibility of a subjectivity "constructed in different – potentially more liberating – ways" and that individuals play a role in their own self-constitution (A. Allen, 2000, p. 125). Recognising 'discipline' as a very important technique, Foucault began to consider it as only one aspect of the art of governing. Thinking about "the way a human being turns him - or herself into a subject" (Foucault, 1983b, p. 208) led to two different but related concepts of how power shapes the modern subject – concepts he coined 'biopower' and 'governmentality'.

Biopower/Governmentality

The concepts of biopower and governmentality represented a further development in Foucault's thinking in the sense that "power relations had become progressively governmentalized, that is to say, elaborated, rationalized, and centralized in the form of, or under the auspices of, state institutions" (Foucault, 1983b, p. 224). However, he stressed these ideas did not supersede disciplinary practices, rather: "we need to see these things not in terms of the replacement of a society of sovereignty by a disciplinary society by a society of governmentality, in

reality one has a triangle, sovereignty-discipline-governmentality" (Foucault, 1991b, p. 102). Thus, an ensemble of disciplinary techniques (surveillance, examination and normalisation), domination and government of others and self may be used to achieve particular ends.

In the final chapter of *The History of Sexuality,* Foucault noted "one of the characteristic privileges of [juridical] sovereign power was the right to decide life and death" (Foucault, 1990, p. 135). The right of death came to be replaced, however, by the power over life and how to secure, extend and improve it. Foucault called this new form of power 'biopower', taking two main forms. First, in the manner of disciplinary technologies, the body is treated as a productive, economically useful machine, creating a more effective population. Second, in the regulation of population, the health, mortality, longevity, and particularly reproductive capacity contributed to the development of capitalism (Foucault, 1990). Foucault argued that capitalism "would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes" (Foucault, 1990, p. 141). In this sense, the introduction of *economy* into political practice was the essential issue, positioning the population as an "object in the hands of the government" (Foucault, 1991b, p. 100).

The realisation that government was not only dealing with subjects, or people, but populations coincided with the human science disciplines which developed the ability to quantify the population in terms of "birth and death rates, life expectancy, fertility, state of health, frequency of illnesses, patterns of diet and habitation" (Foucault, 1990, p. 25). This led to the discovery that if the population could be analysed, it could also be a target of intervention. By employing new tactics and techniques to the population, the economy of a country can develop, which in turn benefits the population. Hence the new power, biopower, subjected human life to politics.

Connecting the question of government and politics to the self more securely is the concept of governmentality. Foucault maintained it was "not possible to study technologies of power without an analysis of the political rationality underpinning

them" (Lemke, 2001, p. 191). As a practice of governmentality, the central rationality of liberal and neoliberal thought is to limit governmental activity, and this is achieved by continually encouraging autonomous individuals to self-govern (Foucault, 1997a). Using indirect techniques, the state leads and controls individuals, rendering them 'responsible' for problems of self-care (for example, for health, employment and wealth). Governmentality became the term coined by Foucault (1988) to explain the rationality of government, but more precisely the encounter between technologies of the self (explained further in the next section) and technologies of domination.

So governmentality encompasses an ensemble of techniques targeted at the population as a means to 'conduct the conduct' of people. It is a "politics concerned with subjects as members of a population, in which issues of individual … conduct connect with issues of national policy and power" (Gordon, 1991, p. 5). Rather than imposing law on people (although this may be used), governmentality makes use of knowledge and expertise to educate and persuade a population towards particular behaviours coincident with government ambitions (Rose & Miller, 1992) and with the intention of maximising life (Lacombe, 1996). Thus Foucault's theorising on the constitution of the self involves "a subtle integration of coercion technologies and self-technologies", connecting relations of power and knowledge with relations to oneself and to others (Foucault, 1993, p. 204).

Technologies of the self

Foucault's ideas on the constitution of the subject suggest that individuals are, or can be, active and self-governing agents. Through a series of techniques, individuals work on themselves to regulate "their bodies, their thoughts, and their conduct" (Danaher et al., 2000, p. 128). The desire for an individual to act upon him or her self is driven by the current regime of truth. Foucault (1997c, p. 224) warns against accepting this knowledge "at 'face value', but to analyze these so-called sciences as very specific 'truth games' related to specific techniques that human beings use to understand themselves". Self-governance techniques of self-care and self-improvement are tied up with a neo-liberal rationality of lessening an individual's burden on society. An example is of the notion of 'risk' in public

health discourse in which combinations of abstract factors predict the likely occurrence of disease in later life (Petersen, 1997). An individual is able to modify his or her risk by engaging in particular health-promoting behaviours, such as smoking cessation, weight loss, exercise and eating healthy food.

The introduction of the PHC Strategy (Ministry of Health, 2001b) and the nurse practitioner role to New Zealand are examples used in part three of this thesis to illustrate how governmentality and technologies of the self can be applied theoretically. As regimes of truth, both harness and direct health practitioners less towards a system of constraint and more towards "a kind of regulated freedom" (Rose & Miller, 1992, p. 174).

Another technique of the self involves the knowledge of oneself, discovered and formulated through practices of self-examination. Originating with Christian practices of confession to a priest, the secret truth of the self is explored in the sharing of thoughts and deeds with a friend, an adviser, a guide, or in the keeping of a journal (Foucault, 1993). The purpose of self-examination is to transform the individual "to become competent to take up a position in society that would not harm others, and that, through the exercise of 'proper' relations, would benefit the community as a whole" (Danaher et al., 2000, p. 130).

Foucault argues that governance serves to structure "the possible field of action of others" but can only be exercised over subjects who are free to choose (Foucault, 1983b). Thus, personal autonomy (the freedom to choose) becomes key to the exercise of political power (Rose & Miller, 1992). Much more than compliance with a set of rules, the freedom to constitute oneself in particular ways – or to choose not to – becomes a question of personal, and in this case, professional ethics (Foucault in Luxon, 2004). These theoretical ideas are used in chapter ten to illustrate the nurse practitioner subject, who is no longer defined by the power/knowledge regimes of others but is free to "actively and reflexively constitute themselves via a particular kind of ethical relation to self" (A. Allen, 2000, p. 118).

Summary

This chapter has presented the key theoretical concepts used throughout the thesis to inform the analytical process employed to examine the construction of the nurse practitioner role in New Zealand. Adopting a postmodern epistemology rejects the metanarrative of a rational, stable and ordered construction of nurses and nursing and leads to an inevitably partial analysis of the discourses shaping the nurse practitioner identity. A deconstructive approach, in which language is considered to be constitutive, allows for a focus on texts and questions the priority of things seen to be self-evident, such as the hierarchical relationship of doctors to nurses.

Foucault's historical method of analysis, genealogy, accounts for the way in which subjectivity is constituted by discourse, emphasising historical events marked by shifts and reversals in relationships, where power is usurped and vocabulary appropriated. The method problematises those disciplines that produce knowledge and generate norms to which individuals then conform. Discourses are, therefore, bodies of knowledge constituted by power, producing possible subject positions. No longer is power conceived of solely as hegemonic; it is deployed via a number of tactics and strategies involving disciplinary techniques of surveillance, normalisation and examination to produce a body that is both docile and useful.

Historically, the nurse as subject is constituted through disciplinary techniques of objectification that maximise productivity; or, appreciating the productive notion of power, a nurse turns him or herself into a subject through technologies of the self. Rather than resorting to techniques of domination, the art of government is to make use of knowledge in such as way that a given population is conducted towards particular behaviours consistent with the current political rationality, and this in turn benefits the wider population. Enabling a more autonomous subject the freedom to constitute oneself without reference to the power/knowledge regimes of others produces 'another' and not 'other' (Cheek, 2000) type of health practitioner, the nurse practitioner. Foucault's theoretical toolbox raises

possibilities for the nurse practitioner role to define itself within a *nursing* epistemology, informed by, but not subject to other forms of knowledge.

Chapter 3: Methodology

> Constructing history can be compared to the construction of a sandwich. It is always best to prepare your own, and with mustard (Winterson, 1996.)

Introduction

As explained in chapter two, this qualitative study is informed by the writings of philosophers such as Foucault, Derrida and Lyotard. I am guided by postmodern and post-structural epistemological perspectives that challenge and critique assumptions about claims to truth and interrogates language, meaning and subjectivity (Weedon, 1987). A discourse analysis methodology that operationalises the principles and theoretical assumptions governing the research was utilised with guidance from various discourse analysts such as Fairclough (1993), Cheek (2000), Carabine (2001), Riggins (1997), Wetherell, Taylor and Yates (2001a), and Stuart Hall (1997, 2001b). That there is no single understanding of discourse analysis is evident in the variety of approaches these writers take. A single prescriptive study design or method is neither possible nor desirable. What is of paramount importance to discourse analysis, as with all research, is alignment between theory, methodology and method.

This chapter starts out with an overview of the methodological principles driving the study and then outlines the specific analytical tools employed to uncover voices subjugated by the power and control of more dominant discourses. Later sections describe the research methods, tracing the steps in the research process I have taken to obtain ethical approval and conduct interviews, as well as my use of qualitative data analysis software during the project. I also track the analytical process used, drawing on notions of methodological transparency and reflexivity. Excerpts from my project journal and other formative 'evidence' that has guided the analytic process are included. The final section offers a critique of the truth status of my claim to a transparent account of the research process I have followed.

The approach to discourse analysis used in this study

The connections between meaning and language have been the subject of different theories about how language is used to represent the world and have lead to three broad categories of inquiry: the reflective, the intentional and constructionist approaches (S. Hall, 1997). According to Stuart Hall, reflective theories of representation approach language as if it were a mirror, reflecting meanings that already exist in the world; whereas intentional approaches assume language is used to convey only what an author intended. Of interest to this study is the constructionist approach, which is concerned with how meaning is constructed through language. It comprises two distinct branches of analysis, that of semiotics and the discursive.

Semiotics is derived from the work of Saussure, who proposed a 'scientific' model of language that became known as structuralism (Audi, 1995). Like binary pairings, Saussure insisted that it is the *difference* between signifiers that give the signified their meaning. Meaning thus becomes relational and is subject to change and to history (S. Hall, 1997). It is difference that has importance because "this approach to language *unfixes* meaning … and opens representation to the constant 'play' or slippage of meaning, to the constant production of new meanings, new interpretations" (S. Hall, 1997, p. 32), and interpretations can never result in a final and complete truth.

The discursive approach to discourse analysis is also constructionist, but was not considered by Foucault as structuralist. While many saw his early work this way, he refuted the claims in his conclusion to *The Archaeology of Knowledge (1989).* He also remained noncommittal about the label of post-structuralist, suggesting that it was not necessary to know exactly where he fitted, other than as a "historian of thought" (Foucault in Martin, 1988, p. 10). He did agree with the structuralists that language and society were shaped by rule-governed systems, but he did not think that there were unifying underlying structures in *language* that could explain the human condition. Foucault's interest lay not just in meaning through language, but rather on *discourse* as a system of representation (S. Hall, 1997, 2001a).

Moving away from discourse solely as a linguistic concept, Foucault's notion of discourse concerned the ways that an issue or topic is 'spoken of' through such means as speech, texts, writing and practice (Wetherell et al., 2001a). A set of ways of referring to a topic is said by Foucault to belong to the same discursive formation (S. Hall, 1997). The constructionist view is that language is more than simply a system of representations of physical things and actions, but that they take on meaning as they are spoken of within discourse (Weatherall, 2002). Foucault (1989) argued that nothing has any meaning outside of discourse, and suggested that because knowledge is concerned only with what is meaningful, discourse produces knowledge. The constitutive nature of discourse produces the objects of which they speak, constructing a particular version that is construed as real. Thus 'truth' is defined and established by discourse (Carabine, 2001) and has material effects or consequences (Weatherall, 2002). The 'truth' then has a bearing on how something is controlled and regulated (S. Hall, 1997).

Control is achieved and regulated by the use of techniques such as dividing practices, which delineate normal from abnormal. In post-structural terms, the boundaries of what is acceptable and appropriate are created against a discourse of what is 'normal' or 'natural' as an effect of the cultural and political order (Carabine, 2001). However, these normalisation techniques construct binaries that serve to create a devalued notion of the 'other'. Challenging and dismantling the assumptions underlying hierarchical binaries is the aspect of Derrida's general deconstructive method that I wish to integrate with a discourse analysis after the style of Foucault. This may seem surprising given the acrimony between Derrida and Foucault, but a plural approach of textuality and discursivity has greater potential than either on its own. Foucault's position is that a text can best be read against its context of discursive practices (Boyne, 1990), whereas "Derrida valorizes and gives voice to otherness by subverting the dichotomies of presence/alterity on which Western philosophy, culture, and society rest" (Agger, 1994, p. 502). For Foucault (1989), nothing has any meaning outside of discourse, and for Derrida (1976, p. 158), "there is nothing outside of the text".

Eventually Foucault and Derrida found common ground in relation to power and ethics. Both imply an allegiance to Kant's categorical imperative[8]: Derrida in his writings against racism and Foucault in his commitment to practical political activities (Boyne, 1990). Central to the work of both is the operation of power; however, as Boyne (1990, p. 2) suggests, "the concept of power that is only implicit in Derrida's work is made explicit by Foucault". While Foucault deliberately rejected a top-down characterisation of power based on binary structures (such as oppressor/oppressed), my reading of Derrida suggests that power lies within the Western philosophical assumptions that maintain an opposition.

I see the fusion of ideas from each of these writers as fitting for my area of study because even a general scan of the literature about nurse practitioners reveals 'othering' (particularly by medicine) as a striking feature. However, my research interest is also in the wider formative and transformative statements that gave rise to the possibility of a nurse practitioner role for New Zealand and of its subsequent development, and Foucault's approach offers productive possibilities to examine this.

Fairclough (1993), too, adopts a multidimensional approach to the analysis of discourse and brings together three analytical traditions. Although his view of discourse as text is narrower (in a linguistic sense) than I have adopted, and his understanding of power different from that of Foucault, his work in particular has informed many aspects of the general approach I have taken to the handling of data in this study.

Techniques of analysis

In the absence of specific and practical directions on how one might apply understandings of discourse to text, I am encouraged by my reading of Fairclough (1993) to borrow from the traditions of more than one philosopher to establish which techniques will be useful for this study. It was Said (1983) who suggested "Derrida's criticism moves us *into* the text, [and] Foucault's *in* and *out"*(p. 183)

[8] Act so as to use humanity, whether in your own person or in others, always as an end, never as a means.

and it is these notions I draw on to operationalise their methodologies into method. Both Foucault and Derrida agree that the text hides something, and the "countervailing power of criticism is to bring the text back to a certain visibility" (Said, 1983, p. 184). Each goes about that purpose in different ways. Derrida employs what I shall call (after Fairclough) a 'micro-analysis' of text, moving *into* the text to describe the processes that shape and position subjects. Such a description is complementary to and provides evidence for the 'macro-analysis' of Foucault's genealogical approach, moving *in* and *out* of the text to interpret discursive practices. Thus micro- and macro-analyses are "mutual requisites" and interrelated techniques (Fairclough, 1993, p. 86).

A micro focus on text: In-text tools

Closer to a linguistic analysis than Foucault's work, critical discourse analysis "aims to show non-obvious ways in which language is involved in social relations of power and domination, and in ideology" (Fairclough, 2001, p. 229). As such, there is an emancipatory political intent to critical discourse analysis that differs from the political intent of Foucault. Largely informed by the Marxism of Althusser and Gramsci, critical discourse analysis views power as hegemonic, an idea also present in Derridean understandings of hierarchy in binary oppositions. Yet this runs contrary to Foucault's understanding of power unless one considers, as Hall (2001b) argues, "that everyone – the powerful and the powerless – is caught up, *though not on equal terms*, in power's circulation" (p. 340, italics in original). Thus, uncovering alterity provides an opportunity to deconstruct the circularity of power and its techniques of counter-discourse production. Although deconstruction is less method than perspective (Cheek, 2000), Riggins (1997) usefully reviews a number of language techniques employed by various analysts that can be used in the interrogation of texts in the examination of othering. The 'other' is understood by Riggins as those mildly or radically different to the self, as either unique individuals or collectivities thought to share similar characteristics.

The techniques Riggins (1997) describes are presented next (paraphrased) as characteristic of the tools used to examine the texts and visual images, such as television and photographs, chosen for analysis in this study. Only the techniques

used to analyse texts in this study are presented – Riggins' list contains other techniques I did not use. For simplicity, in an adaptation of Said's (1983) "*in* and *out"* of the text, I refer to these tools as 'in-text' tools, and Foucault's as 'out-of-text' tools (described later).

Difference and similarity. In the search for self-identity, internal discourses identifying both difference and similarity are generated. When applied to nursing epistemology, nurses practise differently to physicians, yet seek similar recognition of skill, education, and funding structures.

Distancing. Value judgments of good/bad, superior/inferior of others are compared to one's self; both physical and psychological distance is maintained; and knowledge of the other's history and culture is limited, serving to maintain distance between the self and the other. Distancing is sometimes marked in the text with distance markers such as quotation marks and phrases, for example, 'according to', and 'said'.

Mitigation and disguise. Discrimination against particular groups is disguised in a text by lessening the speaker or writer's intent with the choice of softer terms that may be less inflammatory.

Victim-victimiser reversal. Reversal occurs when "members of a dominant majority, historically part of a class of victimizers, claim they are being victimized by attempts to achieve social justice" (Riggins, 1997, p. 8).

The mode of identifying. Members of dominant groups tend to be identified by personal names, whereas others are identified anonymously in terms of age, occupation, or a collective name in popular usage. An example in chapter nine is where the medical doctors in a text were referred to by their title of doctor, but the professor of nursing's title was omitted.

Inclusive/exclusive pronouns. Inclusive and exclusive pronouns such as 'we and they', 'us and them', may fluctuate throughout the text, revealing contradictory messages about the boundaries between self and other. Possessives such as 'ours and theirs' are equally revealing.

Stereotypes. Stereotypes are described by Riggins as one of the major discursive strategies ensuring difference is recognised. They are usually both repetitious and contradictory. For example, nurses are depicted doing low-tech jobs, while doctors are shown in high-tech, intensive-care-type environments (see chapter nine).

Presence/absence. In addition to Derridean notions of hierarchical binaries, Riggins refers to presence and absence as the self-evident truth of a text, where information can be variously *foregrounded,* (ideas that are present and emphasised); *backgrounded* (stated but de-emphasised); *presupposed* (implied or suggested); or *absent* in the sense that relevant information is not supplied or even implied.

A hierarchy of meaning. The voice of the dominant group presents a more 'complete' version of the truth than the 'incomplete' voice of the subordinate group. 'Inoculation' is a technique where an aspect of the counter-discourse is presented to convey a sense of objectivity.

Characterisation. Riggins suggests the characterisation of others "as odd or irrational is a powerful strategy of exclusion used by a dominant majority that sees itself as rational and normal" (Riggins, 1997, p. 17).

A macro focus on discourse: Out-of-text tools

> All my books … are little tool boxes ... if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including eventually those from which my books have emerged ... so much the better (Foucault, 1975 cited in Patton, 1979, p. 115).

Foucault gave little specific direction as to how a method of genealogical analysis could be conducted, although he did provide clues about what might be looked for in the search for subjugated knowledges. A toolbox approach, as Foucault suggests above, centering on concepts of discourse/power/knowledge was used in this study combined with particular aspects of Foucault's work (examples are disciplinary practices, normalisation, governmentality, the Panopticon) that had resonance with the power and forms of knowledge circulating and gave rise to the nurse practitioner movement in New Zealand.

Discourse was viewed by Foucault as "systems of knowledge (e.g. medicine, economics, linguistics) that inform the social and governmental 'technologies' which constitute power in modern society" (Fairclough, 2001, p. 233). A genealogical discourse analysis, although partly concerned with language, is a

macro approach to discourse that describes "the procedures, practices, apparatuses and institutions involved in the production of discourses and knowledges and their power effects" (Carabine, 2001, p. 276). The purpose of writing a 'history of the present', a tracing of knowledges and power effects, is not about generating a 'truer' version of the truth (as this would indeed be a counterintuitive power-effect in itself) but rather, to generate critique (Hook, 2005). Such a critique looks beyond the text itself by taking into account the role of history, focusing on discourse-as-knowledge, and making reference to materiality. In other words, the analysis of the discursive is driven not by textual semantics but *"through the extra-discursive"* … "both *in and out* of the text" (Hook, 2001, p. 543).

In *The Subject and Power* (1983b, p. 223) Foucault suggests that an analysis of power and knowledge relations needs to consider the following points (paraphrased):

The system of differentiations. These are the differentiations between individuals that incur a relationship of power that is determined by the law, traditions of status, and privilege; economic, linguistic or cultural differences; and differences in know-how and competence.

The types of objectives. What is the goal or the reason for the power? How are privileges maintained, profits accumulated, and statutory authority brought into operation?

The means of bringing power relations into being. Of interest is the way in which power is exercised, for example, by force, by the effects of the word, by economic disparities, by surveillance, by rules (explicit or otherwise), or by technology.

Forms of institutionalisation. Power is institutionalised through the law, custom and fashion and contain carefully defined hierarchical structures with relative autonomy of function. The state, for example, has multiple and complex systems of general surveillance and regulatory control.

The degrees of rationalisation. Is the exercise of power justifiable in terms of ease of exercise, cost, and is it worth the resistance it is likely to engender?

These points raised by Foucault form part of the analytical tool-kit employed as 'out-of-text' tools in this study. For the task of determining particular discourses

at play, the following questions Foucault asks of a text have focused attention on the different discourses in the wider historical context and the purposes those discourses serve as well as the power/knowledge implications. The questions are: "What are the modes of existence of this discourse? Where does it come from; how is it circulated; who controls it? What placements are determined for possible subjects?" (Foucault, 1977c, p. 138).

It is important to point out that all of these tools do not in any way constitute a *method* for doing discourse analysis. They describe ways in which a text can at first be *approached* in order to see past the taken-for-granted assumption that a text can be value-free.

To use a seamstress analogy, my experience of beginning with an 'in-text' analysis seemed like unpicking a garment. How the text has been put together to construct a given position becomes clear as the stitching is removed and the individual parts are separated from one another, allowing each piece to be examined. To leave a deconstructed garment in such a way serves little purpose, however, and it must be reconstructed to be of benefit. On the other hand, 'out-of-text' tools like those of Foucault reveal how discourse has shaped the broad design precepts and overall form of the garment. The reconstructive process makes visible those knowledges otherwise subjugated at first glance of the complete and 'truthful' garment. What is now known is how the text (or garment) was put together, and there is opportunity to critique and challenge the discourses that constructed it. As Boyne (1990, p. 167) points out: "The elimination of the historical tendency to create the other cannot be simply dissolved, but the hierarchical demotion of particular others can be continually challenged. Such challenges constitute the political imperative of deconstruction".

As a brief aside, from time to time throughout the thesis I use the literary device of metaphor. Richardson (2000) encourages its use because one often understands through the experience and understanding of other things. Sewing has been a part of my life since I was sewing dolls clothes as a three-year old, and so my writing gravitates to metaphors that compare the research process to dressmaking activities. I also use the story of Alice in *Through the Looking Glass* in chapter six

where the outrageous and tyrannical nature of the Red Queen helps to make sense in a playful way of the power relations under discussion.

Returning to my experience of using the tools, two journal entries on successive days describe how I went about using them:

> **Journal entry 18 August 2005**
> I started with a print out of both the in-text rules and the transcript. At first I simply could not see any great insights, but by the end of half an hour I was writing all over the transcript ideas that showed 'othering'.
> However, while the ideas might be there, it is not easy writing formally about it. I need to work out a style and some conventions I will conform to. For example, do I use the names in the script in my analysis or do I refer to role? I am astonished how little detail there is in other PhD work I've been reading about how to do this!
> Looking first at the text in this way using the in-text tools is the first level of writing. My plan is to proceed with a second level of writing that uses Foucault's guidelines – I think it will help my writing be more theoretical. At the moment it is quite a jumble of description and observations about the text, without any sense of what is going on from a discourse perspective.
>
> **Journal entry 19 August 2005**
> Spent yesterday incorporating Foucault's 'out-of-text' guidelines. They do drive the level of theoretical analysis up, and tend to leave the 'in-text' tools behind in a cloud of description. Foucault's focus is explicitly on power and that is inescapable when using his tools. The in-text tools have a more implicit application of power, and I can't help wondering if the tools uncover completely unintended meanings that aren't entirely fair to the writer or speaker. But then isn't that the whole point? That language constructs that which it speaks of – that there are unintended consequences from the use of language. I have found that using the in-text tools 'opens' the text up so you can get a closer look to see what's going on and then use the out-of-text tools.

The concern raised in this journal entry is about the intentions of the author of a text, and I question if an author is deliberate or unthinking in his or her choice of words. Foucault tends to refer to statements that have attracted his interest simply as statements, but Dreyfus and Rabinow (1983, p. 48) prefer to call "these special speech acts *serious speech acts*". By this they mean that a speech or publication prepared for a particular occasion or circulation is validated by the expert status of the author as a truth claim and carries more weight than if it were said in passing as a casual remark in the course of everyday life. Given the constitutive nature of

discourse, the material effect of language use is the construction – intended or otherwise – of the object of which it speaks. The issue for Foucault was to stay neutral about the truth claim and to focus instead on "how it fits into the discursive formation" (Dreyfus & Rabinow, 1983, p. 49). The choice of texts for analysis that fit into a discursive formation is discussed next.

Selection of text

Fairclough (1993) refers to the collection of discourse samples as 'the corpus', meaning a collection of writings. Similarly, Foucault (1989) discusses the 'archive', not wholly in the sense of a collection of documents, but as the general set of rules that form and transform discursive statements. Foucault's archive exists only to reveal "the conditions ('the set of rules') by which it is possible to 'know' something at a specific historical point and by which this knowledge changes" (McHoul & Grace, 1993, p. 31). For simplicity, the collections of texts used in this study are named the corpus.

In the first instance, descriptive materials found in documentary sources need to be selected on the basis that their content links to current concerns and have the potential to reveal relationships of power. According to Taylor (2001), "what counts as data will depend on the researcher's theoretical assumptions, about discourse and also about the broad topic of the research" (p. 24). There is also the need to distinguish between what is data that will be analysed and what is useful contextual information. Cheek (2004, p. 1146) expresses an ongoing tension "between the text and the context in which the text is situated" and the dilemma deciding how much detail beyond the text in question is needed to convey a reasonable sense of context for the reader.

A commonly used way of enhancing the corpus is through interviews where the people identified in corpus samples can contribute their interpretations as participants of particular events (Fairclough, 1993). Interviews conducted specifically for this study were audio-recorded and transcribed and became textual data, as did the transcript of a television news item. It should be said, however, that interview data was not privileged as a form of discourse "somehow more

primary or authentic than other forms" of text (Ogle & Glass, 2006, p. 96) and so was not necessarily chosen for analysis in preference to published text.

The collection of data for the corpus in general was relatively straightforward and involved searching university library databases of academic journals and catalogues for publications that relate to nurse practitioners, advanced nursing practice, and the regulation of nursing practice. Publications and policy documents produced by the Ministry of Health, the Nursing Council, and health professionals' organisations, including documents located on associated Internet sites, have also contributed to the corpus; also newspaper items, photographs, and advertisements. More unusual, perhaps, has been the inclusion of electronic mail submitted to a discussion board and used with the express permission of the author of the post.

Foucault "wrote that, whenever possible, he would employ a 'concrete example' to 'serve as a testing ground for analysis'" (Rabinow, 1997, p. xi). I, too, have sought concrete examples from within the corpus for detailed analysis. Selection is not always straightforward, yet it is critically important to the study outcomes. Fairclough (1993) offers a selection strategy that focuses on what he calls 'moments of crisis' or moments when things go wrong. Although Fairclough takes a more linguistic approach to texts as he identifies these moments, I liken his strategy to Foucault's concept of the 'epistemic break' and understand this to mean where one system of knowledge or power falls and another takes its place. Texts illustrative of a disruption to an existing regime have therefore been the focus for selection in this study. An example is recorded in my project journal of a decision to choose a television news item about nurses' prescribing rights as a text for analysis (L. Mason, 2005, July 29). The journal entry identifies a challenge to the existing medical regime of control over prescribing:

> **Journal entry 8 August 2005**
> My thoughts today re. prescribing are that both medical and nursing professions are each desperately creating a 'will to truth' that will become the dominant discourse and therefore sway current policy decisions. Am wondering if transcribing the TVOne news item video would be useful since it showcases each position in quite useful ways.

I did proceed with analysis of the news item and it comprises a significant portion of chapter nine. The remaining sections of this chapter deal with the practical management of the research project with respect to ethics, study participants, qualitative data analysis software, and the construction of the data analysis chapters. As a person writing from a particular position at a specific time, I make a "conscientious effort to 'tell the truth' about the making of the account" (Gergen & Gergen, 2000, p. 1028). Known also as 'reflexivity', accountability for the analysis is enhanced when interpretive processes are made publicly available for evaluation (Burman & Parker, 1993). Richardson (2000) suggests that a post-structural perspective incites reflection on method, and to do so I position myself more prominently in the remaining sections of this chapter than I have elsewhere in the thesis. Lincoln and Denzin (2000, p. 1051) discuss the extent to which the personal should have a place in a scholarly text and suggest it is impossible "for an author to write a text that does not bear traces of its author". I include excerpts from the journal in which I documented my thoughts and decisions for much of the project, and examine, in places, my own subject position as nurse, student and author/researcher.

Ethical considerations

The epistemological foundations of this study have led me to consider conventional research ethics as a technology of the self, a technology that acts upon my self, the researcher. I ask as Foucault (1983a) asks, what determines how an individual constitutes himself as a moral and ethical subject? By this I understand that although I must conform to particular activities and scripts established for the conduct of ethical research, I do so in such a way that I create a particular subject position for myself.

To explore this subject position, I make use of four aspects of the relationship to oneself described by Foucault (1983a), and while his project is a genealogy of the ethical subject, in this section I have sought to apply these aspects as questions to determine what has constituted me as an ethical researcher. The questions are: firstly, what is the right action to take? (*substance éthique);* secondly, by what mode of objectivation are my actions guided? (*mode d'assujettissement);* thirdly, what self-forming activities have guided this project towards the right action?

(*pratique de soi);* and fourthly, what kind of being is it to which I aspire? (*teleologie).* Each question can be answered independently, although they are interrelated.

The 'right action to take' (*substance éthique)* relates to "the material that's going to be worked over" in this project (Foucault, 1983a, p. 238), that is, the parts of the project concerned with the ethical conduct of research. For example, proper acknowledgment of the source of ideas (referencing conventions), seeking ethical review of the study proposal, attending to the relationship with the study participants, the confidentiality of the interviews, handling the transcripts, and analysing the data.

My obligation to act in an ethical manner (*mode d'assujettissement)* is guided by the University Code of Ethical Conduct for Research involving human participants. However, in the day-to-day decisions concerning the data, my conduct is not monitored by the institution, rather it is self-monitored in a technology of the self. One could say my conduct is governed by the University Code, and I accept the obligations of the Code because I believe them to protect the interests of the study participants.

The practical activities that have guided this project (*pratique de soi*) have been in the first instance, submission of a study proposal to the Massey Human Ethics Committee in December 2003. Approval was granted in March 2004 (see appendix two). An information sheet was given to each person when invited to be a participant in the study (appendix three) and consent form signed at the beginning of each interview (appendix four). During the consent process of the first interview I conducted, the participant was not interested in maintaining anonymity and suggested her name be used in the study. In fact, with only one exception, all of the participants were happy to have their name used in the thesis. However, on later reflection when I was writing the analysis chapters, I began to understand that the naming of individuals impeded my overall purpose because of the focus it brought to the authority of the person, rather than the discourses informing the text. As Foucault (1977c, p. 138) asks, "what matter who's speaking?"

Another form of data I collected was electronic posts about nurse practitioners made to the College of Nurses Aotearoa discussion board. These posts are in the public domain and archived on the College website and so are actually 'published text'. However, I felt the author of each post had not written with the knowledge his/her post could be used as research data, and I did not want to post a message advising of the possibility, lest contributions cease. Consequently, I wrote to the Executive Director of the College to ask permission to use the post as data, emphasising that I would seek the permission of the author of any text before I used it in the study. In my early writing, I quoted from a number of these posts, but as time went on, I instead used the data from the discussion board to alert me to current issues that I could investigate further from other 'properly' published sources. As a result, the discussion board posts became pointers or signposts to the discourses I eventually wrote about. I found they affirmed my reading of other documents, and I can say with confidence, that my analysis reflects many of the concerns of nurses working in management and education, those seeking nurse practitioner registration, and existing nurse practitioners.

In the final analysis, only one electronic post was utilised in the thesis in chapter ten and was used with the express permission of the author. Similarly, a photograph has been used for analysis in chapter ten. Permission was sought not only from the publisher of *Next* magazine and the photographer, Stu McKellar Bassett, but also the subject of the photograph, Deborah Harris. These may all seem common-sense courtesies, but readers would not otherwise be aware of the place the College discussion board posts had to direct my inquiry if I failed to mention their importance.

The last of Foucault's questions is to ask what kind of being is it to which I aspire (*teleologie*). Each of these activities, these ethical practices, has constructed me as having conducted an ethical inquiry. This has importance if I "want to have a good reputation" (Foucault, 1983a, p. 240) as a researcher and to be judged as competent by my examiners.

Participant interviews

Supplementing the published texts used in this study are texts obtained from participant interviews. In all there were nine interviews and nine participants: three past or present members or employees of the Nursing Council of New Zealand (NCNZ), two senior politicians, one nurse academic, one member from the New Zealand Nurses Organisation (NZNO), one member from the College of Nurses Aotearoa (the College), and one from the Ministry of Health (MOH). All had an interest in advanced nursing practice in New Zealand and had been influential in how the role had been progressed. Each person is identified in the data analysis chapters by an agreed role or organisation description. Some participants had more than one role or worked for more than one organisation within the health and education sectors in New Zealand. To disclose these multiple roles would compromise the anonymity of those participants, and so a name representative of the general perspective I was seeking was chosen – although clearly a participant with more than one role was informed from more than one perspective. Where there is more than one participant from a category, they are numbered with a numerical superscript, for example, NCNZ[2]. All interview text appears in *italics* and is referenced to the page number of the transcript.

I approached prospective participants directly, either in person or by email, and explained the purpose of the study, inviting them to participate in an interview with me. All those I approached asking to participate agreed to an interview. The range of interview duration was 45 minutes to two hours. For each interview, I prepared a general list of prompts to myself on which to base our conversation rather than to specifically direct the interview. The prompts were written as questions and served as a reminder to me to ask about particular things: they were not in sequence, nor were they a structured set of questions guiding the interview. If a prompt had already been dealt with earlier in the discussion, it was not raised again. I prepared different prompt sheets for each participant because not all questions were appropriate to all participants. For example, the following prompt was asked of a Nursing Council member but not a politician: *"Tell me about the [NP] portfolio assessment interview process. How the panel is selected, what*

happens at the interview?" Not all participants wanted to see the prompt sheet at the start of the interview.

The interviews were audiotaped, and I later transcribed them myself. The transcript was then returned by email to the participant to be checked. Each had the right to delete any parts of the transcript or change the wording: only two transcripts were returned unchanged. Some participants used 'track changes' to amend the transcript which I then 'accepted', and others edited the text directly. Of the latter, I was unsure of how much of the transcript had been changed because when a transcript was returned I saved it 'over the top' of the original file with the same file name, guaranteeing that I could not make use of transcript excerpts that did not have the prior approval of the participant. Another advantage of electronic transmission is that no electronic or hard copy of the original interview is in existence except for the audio cassette tape.

Both Sandelowski (1993) and more recently Angen (2000) are critical of member validation processes, suggesting they are an attempt to establish an exact and 'truthful' account of reality. Acknowledging the connection between epistemology and ethics (Lather, 1993), it is important to note I was not intent on seeking transcript verification as a means to truth, but on meeting my personal and moral obligation to the participants by honouring the terms of agreement for the interviews. In practice, my commitment resulted in the transcript of one interview being discarded after a participant read it and believed we had digressed too far from the topic. She was unsure about how some material might be used and so a repeat interview was scheduled.

The interviews took place in each participant's place of work, generally in their private office. There were few interruptions aside from occasional incoming phone calls or a reminder from a participant's assistant of their next appointment. Because of the senior positions many of the participants held, I entered each interview with a degree of trepidation. In qualitative interviewing, it is usually the task of the interviewer to put the interviewee at ease, but I found the participants were accustomed to and extremely gracious in this task. What I think the interview transcripts betray is my anxiety to demonstrate my knowledge of the

topic, when the purpose was to glean theirs. Had I greater insight into this at the time, I would have failed less often to ask more probing follow-up questions to issues when they arose.

These reflections acknowledge my own mobile and non-unitary subjectivity and challenge the assumption of having made "a set of consistent choices located within only one discourse" (Davies & Harré, 1991, p. 59). For example, the investment made in positioning myself as a doctoral student (mindful of future career prospects) had me anxious to emphasise my knowledge of the field and preparedness for the interview. Yet my purpose would have been better served had I drawn more extensively on a nursing discourse, and practices that utilise listening and reflecting skills, saying less – more often. I share these reflections as critique, but more to draw attention to a postmodern epistemology that includes the ontological position of the researcher. The presumption of a coherent self is the normative writing voice for scholarly presentation (Richardson, 2000), and by positioning myself "as having a mobile subjectivity interrupts the smooth claim to truth of the author while simultaneously also acknowledging that the text is still but an interpretation (a representation) by the author" (Ogle & Glass, 2006, p. 175-6). Readers should therefore remain conscious of an interpretation throughout this thesis that is inevitably partial and subject to the discourses that have produced its author.

Interviewing shortcomings aside, the quality of the interview data was more than sufficient to inform the overall study, particularly as I was able to compare interview data with a range of texts to confirm the emergence of particular discourses. Having collected the data for analysis, the next section is concerned with how the data was managed using qualitative data analysis software.

Qualitative Data Analysis Software

I am, in fact, ambivalent about using NVIVO to aid data analysis in a discourse analysis project, but that is more a reflection on the method I developed to approach the texts than any particular shortcoming of the software. I would not hesitate to use it for other qualitative projects, but the focus on coding was inconsistent with the approach to analysis I have described. I did, however, use it

for a substantial period of time during the writing of this thesis, and so I present my experience.

I decided to use qualitative data analysis software (QDAS) about one year into this project, when I was asked to do a presentation about my experience of using the NVIVO software (QSR NUD*IST VIVO, 1.1[9]) I had used for another project. While preparing for the presentation, I discovered the software had more uses than I had employed it for in the earlier project. Feeling overwhelmed by the amount of data I was collecting for this study (and this was prior to collecting data from interviews), I saw NVIVO as the solution to my data management worries. I used NVIVO because it was available and I was familiar with it, not because it was necessarily the best QDAS tool for discourse analysis.

Treating all text as data, I originally felt NVIVO would suit the epistemology of discourse analysis. Certainly coding text was useful to my purpose insomuch as it helped to group documents or portions of text into common *themes*. While the initial phases of writing are mostly descriptive, the later phases of analysis needed to move from the descriptive to the discursive.

I was, however, attracted to the idea of a transparent audit trail raised by Bringer, Johnstone and Brakenridge (2004), who wrote about maximising transparency in a doctoral thesis by inserting screenshots (electronic pictures of the computer screen) from NVIVO throughout the methodology chapter in order to make the decision trail explicit to the reader. Thus lured, I persisted with NVIVO longer than perhaps I should have and collected screenshots of my progress for a short time. As time went by and I developed an overall structure for the thesis and my writing had shifted to a more discursive approach, I used NVIVO only to retrieve thematically coded interview data that would inform my chapters. I wrote to the overall thesis plan and to the discourse sketches I had created – both of which are explained in the next sections.

[9] NUD*IST stands for Non-numerical, Unstructured Data requires ways of Indexing, Searching and Theorising. Version 1.1 was released in 1999 and there are a number of more current versions that are unfortunately beyond my student budget.

Tracking the analytical process

Using 'discourse sketches'

My writing began to take a productive turn when I understood I needed to shift from a descriptive level of writing to a more critically analytical level. Descriptive writing tends to be explanatory, seeking the reasons for why things are the way they are. Discourse analysis examines the way people are positioned by discourse and looks for contradictions and discontinuities without obligating the writer to resolve an issue. An important moment occurred at the end of a detailed journal entry in which I sought to understand why a nursing group had chosen a particular position. I wrote:

> **Journal entry 15 December 2004**
> Perhaps an answer is not needed. Perhaps I just need to start thinking about where these things position nurses.

It was not long after this realisation that I started to use the questions Foucault (1977c, p. 138) proposed at the end of the essay *What is an author?* That is, "What is the mode of existence of this discourse? Where does it come from; how it is circulated; who controls it? What placements are determined for possible subjects?" I used these questions as a template to create what I called 'discourse sketches'. Under each question, I would bullet point the 'evidence' drawn from participant interviews and my reading of the health-service-related literature that could justify the existence of a particular discourse.

I initially developed discourse sketches for ownership, industrial/unionist, academic, competence, autonomy, and neoliberal discourses. The evidence for a sketch was not exhaustive but was enough to shape my initial thinking about which discourses were at play, and collectively the sketches formed the basis of the structure of the analysis chapters.

Using 'the tools'

Until I discovered the tools for approaching the text described earlier in this chapter, the journey towards writing less descriptively and more analytically was slow. It involved writing and re-writing the same material and did not come easily:

> **Journal entry 3 October 2005**
> The issue is that I continue to revert to description in an effort to put chosen texts in context. I continue to want to draw on 'evidence' that I know is plentiful to illustrate my point. I suspect it is just re-thinking how to write this way – theoretically. My ideas seem to be good, but just need to be written theoretically not descriptively. That's what's hard.

The key to progressing the level of analysis was to formalise my ideas about the approach I would use to analyse the data in combination with the discourse sketches. I wrote in my project journal some thoughts about how the techniques I had planned actually worked:

> **Journal entry 14 February 2006**
> The process seems to involve 3 steps:
> **1st,** I choose the text. Sometimes this is hard and other times, easy. Mostly, I get a feeling that arises from having read widely around the topic that a particular piece of text ably illustrates a power dynamic.
> **2nd,** using mostly Riggins tools, I describe in present tense what I see happening in the text. In one sense I re-state what is said in the text, but the tools help to bring another dimension to what could otherwise be a paraphrase.
> **3rd,** the second stage leads on to Foucault's 5 questions about power relations. This is where the analysis moves beyond description of the text to examine how the words are used discursively to construct representations that permit a relation of power.
> These steps open up the text to consideration of particular aspects of Foucault's work, such as surveillance, dividing practices, governmentality etc. Finally, establishing and naming a discourse within which this text fits is aided by his questions: how does a discourse exist, is it circulated, controlled, creates subject placements?

I had written a great deal about neoliberalism and the New Zealand health reforms of the 1990s and understood a neoliberal discourse as being central to the emergence of an advanced nursing discourse. The changing role of the NZNO was of great interest, and discussions during that decade of a changing notion of nursing 'competence'. Three threads seemed to officially position nursing: the professional voice, regulation, and academia. Consequently, much of part two of the thesis is based on these threads and the events of that decade.

An overall structure

Establishing an overall structure to the thesis was pivotal for me to make headway with writing. Prior to reaching this point, I had 'practised' my discourse analysis technique on a variety of texts (both interview texts and published texts) that

seemed to fit with the discourse sketches I had created. There was no particular coherence or order to what I wrote about, and I recall comparing the process to making a patchwork quilt. Having made a quilt myself (one or twice), I knew that little pieces of fabric are stitched together in a particular pattern to make a 'piece'. When enough pieces are made, they are all laid out to see where each piece will best fit in the overall design of the quilt. The next step is to stitch those pieces together and then to sew a border that goes right around the outside.

Many of my 'pieces' of analysis were aligned with particular discourses, but settling on how these pieces would fit together occurred while reading Elaine Papps' PhD thesis (1997). Her work was presented in three sections, and although other theses I have read are structured similarly, there was immediate resonance with how I needed to present my own work. I had settled on the idea that an interstice had been created by the construction of the competent nurse and paved the way for the *most* expert nurse. 'Practising in the interstice' seemed to capture the subject position for the *most* expert nurse, as well as being a partner phrase to 'creating an interstice'. Dividing the analysis chapters into two distinct categories provided a way to end discussion about competence and focus the last section of the thesis on a new nursing identity, the nurse practitioner.

Like Julianne Cheek (2004), I experienced the tension of deciding how much contextual information should be included for a reader (especially an international reader) to make sense of any piece of text chosen for analysis. I had planned to include a historical chapter to put the New Zealand health and disability sector in context; however, this eventually proved to be unnecessary because contextual information is included within each of the analysis chapters. The final configuration of chapter appears in the table below.

Part One	Part Two: Creating an Interstice	Part Three: Practising in the Interstice
1. Introduction	4. *Political discourses outside nursing* • Social welfarism • Neoliberalism • The Third Way	8. *Discourses of ownership* • Medical privilege
2. Theory	5. *Political discourses inside nursing* • Discourses of representation • Nurses and nursing	9. *Discourses of ownership* • Prescriptive privileges
3. Methodology	6. *Constructing the Competent Nurse* • Discourse of regulation • Discourse of education	10. *New positionings* "the possibility of new and potentially more liberating modes of subjectivity" (Allen, 2000, p. 125)
	7. *Constructing the most expert nurse* • Convergence of discourses on the Taskforce	11. Conclusions

The contested terrain of maintaining rigour

Having constructed an argument that attempts to provide a transparent approach to the discourse analytical techniques used in this study, attention is now turned to deconstructing the status of this 'truth' (Burman & Parker, 1993). What follows is a presentation of the various competing and contradictory claims to truth about the maintenance of research rigour.

Belonging to a paradigm other than that of post-structural approaches, the positivist trinity of validity, generalisability and reliability is dismissed as inappropriate criteria for this study (Janesick, 2000). What have become traditional and general criteria for *qualitative approaches* are fittingness, credibility and auditability (Beanland, Schneider, LoBiondo-Wood, & Haber, 2000). Fittingness concerns the use of literature to support the concepts emerging from the data and is a less relevant criterion for a post-structural approach, given the literature itself is treated as data. However, fittingness can be applied to whether the chosen methodology was a 'good fit' with the aims of the study.

Credibility concerns member checking of the analysis, and it too is problematic in post-structural terms given its purpose is to establish the 'truth' of the researcher's interpretation. Auditability, however, refers to the provision of sufficient detail for a reader to understand the analytical techniques used to produce the final text. These processes have been described in the previous sections, and inevitably there will be different views about whether a sufficient audit trail was provided, or if perhaps there was too much detail. Including formative evidence such as discourse sketches and project journal excerpts has served as sign posts to the decision trail used, but the detail is constrained by space.

There is also a body of literature that argues these qualitative criteria rearticulate those of quantitative research (Guba & Lincoln, 2000) and a way of assessing and maintaining rigour in postmodern/post-structural research is suggested by Richardson (2000). Eluding the positivist drive to 'validate' findings via methods of triangulation, Richardson proposes that 'validity' can be deconstructed using the imagery of crystallisation. The amorphous nature of the crystal as a prism reflecting and refracting light allows data to be viewed as though it were itself, a crystal. Turning the crystal reveals the multiple layers of meaning, helping to uncover hidden assumptions and perceived 'truths'. Considered in this light, validity is not something to be defined in advance "but must be attended to at all times as the study shifts and turns" (Freeman, deMarrais, Preissle, Roulston, & St Pierre, 2007, p. 29). Rather than being a question of method, Rolfe (2006, p. 13) argues that validity or trustworthiness "is concerned *not* with whether the data have been rigorously collected but with their interpretation and presentation".

Pertinent to the presentation of a discourse analytical methodology are some of the common shortcomings identified by writers such as Antaki, Billig, Edwards and Potter (2003). 'Under-analysis through summary' refers to an over-emphasis on presenting the data and then summarising the data without actually doing anything with it (Antaki et al., 2003; Burman & Parker, 1993). Similarly, 'under-analysis through over-quotation' is when quotes are allowed to stand for themselves without being analysed, or they are used as proof of the author's argument (Antaki et al., 2003). Stevenson (2004) suggests that these problems occur when a researcher is uncertain of how to approach the text. These were

problematic issues at the beginning of this project, but the development of *in*-text and *out*-of-text tools created certainty in the approach I eventually took.

Antaki et al. (2003) also warn against an author 'taking sides' in an analysis. Not simply a case of declaring I did or did not do this, my own position as a nurse is evident throughout the thesis. Parker and Burman (1993, p. 162) suggest those who demand neutrality are "subscribing to a fantasy of non-involvement in the material [in ways] not dissimilar from the traditional methodologies we turned to discourse analysis to escape". It is important also to emphasise that the purpose of a post-structural approach has been to champion subordinate discourses of nursing (Agger, 1994; Parker & Burman, 1993), marginalised in the wider medical discourse of health care.

What discourse analysis is *not* is comprehensively explored by Erica Burman (1991) and Parker and Burman (1993). What these authors also point out is that discourse analysis must make a worthwhile political contribution. Neither politics by itself nor devoid of politics, this thesis has set out to answer the all-important question of how an analysis can be used to clarify the consequences of particular discursive frameworks in the construction of a nurse practitioner identity.

Summary

The purpose of this chapter has been to detail the approach to discourse analysis I have used in this study. Guided by a plural approach of both textuality and discursivity, the techniques of analysis involved a micro-focus on text as well as a macro-focus on discourse. The selection of *in*-text tools informed by Riggins (1997) and *out*-of-text tools informed by Foucault (1977c, 1983b) served as the methodological tool-kit for determining which particular discourses were at play, as well as the power/knowledge implications created by a given discursive framework.

In the hope of enhancing transparency, later sections of the chapter have focused on a reflexive account of how I have used the tools described, as well as my own subject position as nurse, student and author/researcher arising from the process of constructing the text of the research report. How I am constructed as an ethical

subject is determined by the extent to which I conform to particular activities established for the conduct of ethical and convincing research. Above all, this chapter reiterates that the interpretation offered in this thesis is inevitably partial and subject to the discourses that have constructed its author. In the next part of the thesis, *Creating an Interstice,* and using the tools described, I trace the political discourses that have shaped how nursing has been represented and the space created from where the *most* expert nurse, the nurse practitioner, could emerge.

Part Two: Creating an interstice

Part two of the thesis comprises four chapters. In chapter four, the political discourses of welfarism, neoliberalism and the Third Way are examined as practices of governmentality and as background to the constitution of the nurse practitioner role. Three successive historical periods coincide with these discourses to reconstruct health services in line with the current and ascendant 'regime of truth'. These discourses are outside or external to nursing, and this chapter considers how each has impacted on nurses and nursing and the spaces created by successive restructuring processes for an advanced nursing role.

Chapter five considers the political discourses that are internal to nursing, outlining the ways nurses have been represented professionally and industrially. Examined are the disciplinary techniques used by both medicine and a hierarchically organised nursing service to construct a docile and useful labour force. Also analysed are emergent discourses of autonomy coincident with a shift to tertiary institutions for pre-registration nursing education. Chapter six scrutinises the education and regulatory practices that have constructed the registered nurse as competent and from which notions of nursing 'expertise' have arisen, forming the basis for the development of the *most* expert nurse, the nurse practitioner.

Finally, chapter seven traces the struggle within nursing for power to control the future of advanced nursing practice. The discourses examined in previous chapters converged with the establishment of the Ministerial Taskforce on Nursing in 1998, producing various clashes between discourses to position an advanced nursing practice role of nurse practitioner within a state-sponsored regulatory framework. Thus, these chapters comprise a genealogy of a radical shift in perspective of how nursing is represented. No one person is responsible for this emergence; rather, the play of forces has created a clearing, a space, an interstice (Foucault, 1977b) from which the nurse practitioner role in New Zealand could emerge.

Chapter 4: Political discourses outside nursing

Introduction

The provision of health care services in New Zealand occurs within a social context that is both historically constructed and politically laden. This chapter provides a sketch of the dominant political discourses that are background to the constitution of the nurse practitioner role and that resurface throughout the thesis. The power of discourse to constitute the subject occurs by the production of "regimes of truth" which are "linked in a circular relation with systems of power which produce and sustain [them]" (Foucault, 1980a, p. 133).

Three regimes of truth are presented here: welfarism, neoliberalism, and the Third Way. Each has produced a particular construction of health care services, which in turn has shaped the available range of possibilities for the medical and nursing professions and for the population in general. The issue is not whether one of these discourses is right and the other wrong, or good and the other bad: the issue is, as Foucault (1983a, p. 231) points out, "that *everything* is dangerous". By this he means that power comes to play in all aspects of human relationships, whether they are interpersonal or political, and that power is productive. The nurse practitioner subject is therefore produced not in a neutral environment, nor one constructed wholly by nursing but, according to Foucault, always in relation to particular discourses.

Foucault's (1991b) notion of governmentality is used throughout the discussion to illustrate the rationality of governmental techniques to enhance social health. The population is an object in the hands of government, with the economy as the science and the technique of intervention. By its very nature, a government can apply techniques to a population that allow the economy to develop, which in turn benefits the population. Different techniques are used within different political discourses, but the goals, if not the outcomes, are similar.

In this chapter it is argued that each of the dominant political discourses in New Zealand's history have brought their respective influences on the structure of

health care services, and in particular nurses and nursing. The productive power of politics to create an interstice from which the nurse practitioner role could emerge is discussed.

Three regimes of truth

The political ideologies that have been dominant in New Zealand during the 20th century and are discussed here are welfarism, (neo)liberalism and the Third Way. As regimes of truth, each in turn has made available particular subject positions for individuals as legislative processes and a growing body of knowledge about such things as economics and politics 'conducts the conduct' of the population (Gordon, 1991). The theoretical framework for each regime is presented briefly in this section and is followed by consideration of the spaces (or otherwise) created for an advanced nursing role by each of these regimes.

Welfarism

Social policy that promotes the well-being of the poor and disadvantaged is known as welfarism. Welfarism is defined by Heywood (1992, p. 320) as "the belief that the state or community has a responsibility to ensure the social wellbeing of its citizens, [and is] usually reflected in the emergence of a welfare state"[10]. Connected with welfarism are notions of social justice and the fair redistribution of wealth to the benefit of the less well-off. In New Zealand, a new regime of truth introduced by the first Labour government and enacted in the Social Security Act, 1938 marked the beginning of the modern welfare state. The Act provided full employment[11] by way of a protected, state-directed economy and provided for those unable to work due to ill health or misfortune. Universally available benefits were paid from a social security tax pool to individuals who met

[10] More specifically, Keynesian economics refers to state intervention in a country's economy to regulate aggregate demand and offset high unemployment. Aggregate demand is based on the macro-economic theory of John Maynard Keynes and refers to the injection of government money into the economy by an increase in public works projects (for example, constructing houses, schools, roads and hospitals), which significantly influences the grand total of all goods and services purchased in the national economy. Following World War II, most Western industrialised capitalist countries adopted these interventionist strategies in an attempt to avoid a repeat of earlier market-driven events such as the Wall Street Crash of 1929 and its sequelae of unemployment (Heywood, 1992).

[11] In 1950 there were only twelve unemployment benefits being paid in the entire country (Knutson, 1998). However, this may not reflect the actual number of unemployed, only those paid a benefit.

certain means-tested criteria[12] and covered medical, pharmaceutical, hospital, maternity, and superannuation needs. The scheme was non-contributory, meaning that benefits were available as of right, irrespective of the amount, if any, of social security taxes paid by the recipients of the benefits (McLintock, 1966). In this way, the Act rejected the previous private model of contributions-based insurance and embraced a blend of needs and rights-based models, the latter being founded on concepts of social citizenship (P. Barnett & Barnett, 1999; Ware & Goodin, 1990).

The intellectual origins of social citizenship are in entitlements theory, "where individuals are guaranteed certain rights in society such as equality before the law and equal access to education and health care, as well as the provision of a minimum income floor" (Stephens, 1987, p. 302 – 303). Citizens, therefore, have rights, but there is a reciprocal obligation for another – in this case the state – to honour those rights (Rishworth, 1992). Welfarism as a discourse consists therefore of a coherent system of discursive practices comprising: state involvement in the economy; the assumption of state responsibility for problems of self-care; and, a system of state benefits paid to those meeting certain criteria. That the state will provide in times of individual need has become a universal expectation of New Zealand citizenship, as has the state provision of health care and education (as well as adequate housing in certain circumstances).

The new political regime of the modern welfare state is suggested by Foucault (1983b, p. 215) as the adoption of an old technique of power originating in the church, except that:

> It was no longer a question of leading people to their salvation in the next world, but rather ensuring it in this world. And in this context, the word *salvation* takes on different meanings: health, well-being (that is, sufficient wealth, standard of living), security, protection against accidents.

In the exercise of what Foucault terms 'pastoral' power, the state now cares for the community and each individual (to the grave). Pastoral power is a technique of

[12] The means test was abolished in 1960 and in 1969 a "7.5 percent social security tax was incorporated into the income tax schedule" (Stephens, 1987, p. 306).

governmentality having at its purpose "the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health etc." (Foucault, 1991b, p. 100). The population is the focus of government having both an individualising power and a totalising power (Foucault, 1983b). It is used by a welfarist discourse to safeguard the economy by safeguarding the individual well-being of its subjects.

Neoliberalism

Liberalism stems from the work of Adam Smith (1776), who demonstrated that free markets and competition, without any attention of government, reduce poverty and improve the general standard of living by a phenomenon now termed the 'trickle-down effect' (McGregor, 2001). The dominant ideology of colonialism, a classical liberal approach to governance was the norm in New Zealand and continued until the 1930s when, in response to the Great Depression, it was replaced by the welfare state. A resurgence of liberalism then emerged in the 1970s due to the effects of rising oil prices and the war in Vietnam, as well as increased trade opportunities brought about by improved global communication and travel (Chatterjee et al., 1999). *Neo*liberalism, however, goes further than liberalism to shift the delimitation between state and society to a belief not only in a 'rational' market but to create subjects as 'rational' individuals, with the consequences for self-determined decisions borne by the subject (family and community) alone (Lemke, 2001).

More subtle in effect than classical liberalism, a neoliberal discourse has the state take on new tasks and functions that lead and control individuals without being responsible for them (Lemke, 2001). As such, there is a shift in subject position from the liberal "'homo economicus', who naturally behaves out of self-interest and is relatively detached from the state, to 'manipulatable man', who is created by the state and who is continually encouraged to be 'perpetually responsive'" (Olssen, 2003, p. 199)[13]. Contrary to the earlier welfare period, neoliberalism renders individual subjects responsible for such things as illness, unemployment and poverty, transforming them into problems of self-care. Furthermore,

[13] *Homo economicus* is a term suggesting one acts rationally to obtain the best possible outcome for oneself.

education and health are viewed as normal economic goods, subject to the market and not the provision of the state (Stephens, 1987). Consequently, the neoliberal ideology in New Zealand rejected the Social Security Act's 1938 notion of social welfarism and the associated dependence of citizens on the state for services such as education, superannuation and health care.

The ideas of political writers such as Nozick and Hayek found appeal in the neoliberal concepts of "'choice', 'devolution', the 'individual' and 'freedom'" (Olssen, 2000, p. 482). According to Stephens (1987), Nozick and Hayek contended the primacy of individual rights and freedom of choice over principles of equality. They viewed redistribution as a threat to those rights, although acknowledged the state's responsibility to provide for a minimum income floor.

Potentiated by capitalism, these right-of-centre theories de-emphasised government intervention in the economy and focused instead on achieving progress and even social justice by more *laissez-faire*[14], free-market methods. Known also as the 'New Right' (and sometimes the 'Second Way'), they incorporated two important theories: Public Choice Theory, referring to the assumption that behaviour in the marketplace is mainly motivated by self-interest; and Agency Theory, referring to the cooperative relationship needed between a principal (shareholder) and an agent (manager) to maximise each other's interests (Wright, Mukherji, & Kroll, 2001). In addition to these discursive practices, a discourse of neoliberalism is a coherent system constituted by: the withdrawal of the state from the economy; generic management principles known as managerialism, emphasising profitability and efficiency; encouraging 'natural' markets to compete by reducing special-interest group capture; and promoting individual autonomy in problems of self-care.

In New Zealand, and beginning in 1984 with a traditionally social democratic Labour government, widespread economic reforms informed by a neoliberal discourse were introduced as a matter of urgency (Goldfinch, 1998; Lange, 1996). The changing international economic situation related to oil production and

[14] The doctrine of unrestricted freedom in commerce; non-interference (Hanks, 1981).

prices, the loss of protected trade with Britain when it joined the European Economic Union, and "massive overseas borrowing to finance new energy projects and maintain domestic spending on a comprehensive welfare state" (Knutson, 1998, p. 8). Treasury briefings to the incoming Labour governments in 1984 and 1987 proposed a radical restructure of the economy and a reduction in the government's role in both the economy and welfare (Treasury, 1984, 1987).

The translation of neoliberal ideology into practice in New Zealand during the 1980s continued with successive National governments through the 1990s, allowing the reforms virtually uninterrupted progress (Kelsey, 1998). Lewis (2004) suggests that the purity, speed of implementation and ideological certainty with which the reforms occurred were regarded internationally as remarkable. Falling broadly into three sequential categories, the reforms increased the use of the market in the regulation of business, reformed the state sector, and redesigned the welfare state (Easton, 1994) – all of which have been documented extensively elsewhere (see P. Barnett & Barnett, 1999; Boston & Dalziel, 1992; Easton, 1994; Jesson, 1999; Gauld, 2001; Kelsey, 1998). Neoliberal welfare reform as it related to the health sector is of primary interest, however, and is discussed shortly.

The Third Way

In 1999 the Labour party campaigned on a manifesto based on the Third Way, successfully forming a minority centre-left coalition government with support from the Green Party (H. Clark, 2002). Following the trend of the British Blair government, two elections later and with new coalition partners, the Third Way as an ideology particular to the Labour party in 2007 no longer features prominently in political discussions or government policy. It is, however, discussed here because of its influence on health policy and legislation when Third Way ideas had greater currency when, for example, the New Zealand Public Health and Disability Act, 2000, and the PHC Strategy, 2001 were enacted during Labour's first term.

On the left of the political spectrum, the 'death of socialism' is said to have occurred with the collapse of communism in eastern Europe and the fall of the

Berlin Wall in 1989 (Heywood, 1992). As a consequence, and due to sustained electoral failure, democratic socialist parties around the world lost intellectual credibility, necessitating the re-examination of core values and their relationship to capitalism and successful economies. An alternative 'Third Way' ideology began to emerge during the 1990s in the US, associated initially with the Clinton administration and then with British Prime Minister Tony Blair and German Chancellor Gerhard Shroeder and coincided with public disenchantment towards neoliberal policies (P. Barnett & Barnett, 1999). As a revisionist version of social democracy, the Third Way critiqued traditional left-wing politics and attempted to go beyond (or perhaps between) capitalism and socialism: neoliberalism and Keynesian welfare (McLennan, 2004).

Prolific writer and Director of the London School of Economics, Anthony Giddens, popularised the Third Way movement, modernising social democracy to take into account the imperatives of "the disappearance of socialist utopias, globalisation, the development of a service economy and ageing populations" (Giddens, 2004a, p. 24). Third Way thinking endeavours to build on, rather than reverse, neoliberal achievements of the 1980s and 90s, accepting the role of capitalism in both industry and the knowledge economy (Heywood, 1992). The Third Way is, therefore, as much constituted by neoliberal discourse as it is by social democracy and welfarism.

Central to Gidden's thesis is the realisation of 'human potential' as people are freed to make the most of their capabilities, moving society towards greater equality (Giddens, 2004b). Emphasising a hand-up rather than a hand-out (Huntington & Bale, 2002), the win-win purpose of Third Way welfare assistance is to support individuals' and families' return to productivity and usefulness in the market economy. Known as 'ladders of escape', this theory is not new, and in the view of Hattersley (1999), addresses neither the broader goal of redistribution, nor the supposed inevitability of economic determinism for those born to poverty.

Not claimed by Giddens – at least in 1999 – to be a fully-fledged political philosophy (Giddens, 1999), McLennan (2004) is critical of the Third Way for its lack of definition. He comments on its evolutionary nature and that it may be

more profitably thought of as ideas with "a limited shelf-life" that "serve to make things happen at a particular time" (p. 485). More cynically, Levitas (2004, p. 42) describes the concepts as deliberately "flexible", designed to be "understood in different ways by different constituencies". Levitas makes it clear that the Third Way is not an *alternate* position to neoliberalism, but "a 'soft' synthesis of market forces and a reliance on 'community' to simultaneously mop up the damage done by market forces and replace, mediate or legitimate the policing functions of the state" (p. 43). Third Way rhetoric therefore serves to reinforce neoliberal hegemony by seeking the same goals of national prosperity but achieves them via another means.

Foucault's (1991b) notion of governmentality provides a useful tool for examining the discursive constructions of politics across the spectrum and the engagement in social ordering via public policy. According to Foucault, techniques of domination and techniques of the self connect to create subjects in *economic* terms, and as "members of a population, in which issues of individual … conduct interconnect with issues of national policy and power" (Gordon, 1991, p. 5). The political rationality of neoliberalism shifts state control onto rational individuals, shifting what were previously political and social issues to become economic and reducing state provided services such as welfare in order to increase personal responsibility for self-care (Lemke, 2001).

Conversely, the Third Way simultaneously promotes prosperity and social justice (Giddens, 2004b) by direct government intervention and serves to attach everyday living to politics, connecting health to the economy by way of a productive labour force (Gastaldo, 1997; Powers, 2003). Foucault's notion of governmentality applies also to welfarism and Third Way thinking as subjects continue to be constituted in economic terms, but now the state assumes active involvement in the reduction of risk to society. By employing new tactics and techniques to the population, the economy of a country can develop, which in turn benefits the population. A particular technique employed by the Labour government for managing the health of the New Zealand population is the PHC Strategy (Ministry of Health, 2001b) and recurs throughout the thesis, but particularly in part three.

Spaces to position nursing

Each political regime has reconstructed health services in New Zealand, maintaining ideological alignment with the economic and social reform taking place at the time. These in turn have shaped the available range of possibilities for the medical and nursing professions and for the population in general. Individuals either take up or refuse various positions made available by these discourses. The following sections examine the spaces created by these discourses from which an advanced nursing role, the nurse practitioner, eventually emerged.

Welfare health reform

Public hospital care under welfarism in the 1940s came to be entirely funded by the state and provided specialist outpatient, elective surgery and acute services. The present-day composition of the public health sector is based on this funding model and an ideology of universal access to care.

However, general practitioners offering primary care services had always operated within a private business model (Fougere, 2001) and during the 1940s rejected the welfarist regime, taking it to infer state control over business independence (Baker, 1992; Blanc, 1949; Sutch, 1966). Choosing rather to remain aligned with a liberal ideology, the introduction of free access to primary medical care for all New Zealand citizens was met with intense general practitioner resistance. Although radical reform of the health care system was the goal of the state at the time, a compromise solution was eventually reached in 1941 with a dual system of subsidised private enterprise that continued to operate alongside the state public hospital system (M. Burgess, 1984). The right of GPs to charge patients co-payments was eventually secured in legislation by amendment to the Social Security Act 1949, and thus secured the future income of GPs (Baker, 1992; R. Barnett, Barnett, & Kearns, 1998; Sutch, 1966).

A doctor writing in 1949, Albert Blanc, described the new era of state-paid medicine as: “where the doctor is not restrained at all in his prescribing and where there is encouragement to over-visit and, therefore, to over-prescribe…” (Blanc, 1949, p. 68). Exploitation of the new provisions resulted in the state pharmaceutical bill alone exhibiting a quarter-of-a-million pounds straight-line

growth, year on year, from 1941–1948 and the income of GPs benefiting tremendously (Blanc, 1949). Illustrating the range of discourses at play, it seems the context of state welfarism paradoxically permitted the natural self-interested behaviour of *Homo economicus* to flourish in both general practice and the pharmaceutical industry. That is, there was a massive increase in market demand for pharmaceuticals (now 'free' to the public with a prescription), and also in the demand for medical monitoring of patients newly prescribed (also substantially paid for by the state). Furthermore, the material consequences of the fee-for-service agreement reinforced an approach to health based on the curative biomedical model that stressed the importance of a medical consultation when sick.

In a scheme initiated by the New Zealand Medical Association and the Department of Health (Hart, 1980), nurses came to be positioned within primary care services by way of a state subsidy intended to relieve "the serious problem of the overworked general practitioner" and in which doctors employed nurses to work as their "extensions" ("Practice nurse scheme extended," 1974, p. 19). In contrast to the position taken by general practitioners to welfarism, a condition insisted upon by the New Zealand Nurses' Association (NZNA) in 1974 when the practice nurse scheme was extended from rural to urban areas was that nursing services would be free to patients. Along with the general medical subsidy, the practice nurse subsidy served to further embed state funding practices of payment to the owners of general practices (that is, general practitioners) and not their employee nurses.

Although universal access to health care served to increase the demand for nurses, it did so predominantly in medically supervised service areas. The possibilities for nurses and nursing in the hospital and in primary care were limited by a representation of nurses as a docile and useful workforce that made it inconceivable for nurses to be considered as other than assistants to doctors (see chapter five). Nonetheless, nurses came to be located in the primary care sector as indispensable, albeit positioned as the employees of doctors in a relationship complicated by vicarious liability. The long-term significance of these practices, along with the insistence of general practitioners to maintain autonomy in fee-

setting, continue to resonate in the 21st century and to construct the primary care sector within a business model, despite an intended regime of state provision. As discursive practices, these issues have continued to resurface and are examined further in chapter eight as constraints on the advanced nursing practice role of nurse practitioner in the primary care sector.

Neoliberal health reform

The neoliberal health reforms of the 1990s occurred within the context of radical social and economic reform described earlier. Similar changes to health care services were occurring throughout the developed world, influenced by changes in medical technology as well as a neoliberal political ideology (McGregor, 2001). Based on generic management principles (or managerialism) introduced by the State Sector Act, 1988 and proposed by a team with management not health experience, the Gibbs Report (Hospital & Related Services Taskforce, 1988) introduced a competitive contracting private sector management model to New Zealand health. It is important to note that the Gibbs Report was dismissed by many, including the Labour government when it was written, as extreme (Kelsey, 1998), but was nonetheless implemented by the National government in 1993.

Implementing a market model, the fiscally austere budget of the National government in 1991 betrayed an ultimate agenda to privatise health care not only by introducing a purchaser – provider split, but by providing people with the choice "to take their entitlement to Government funding for health care with them … to pay the annual fee of their health care plan" (Upton, 1991, p. 61). The government plan to privatise health care never eventuated, but the Minister of Health at the time, Simon Upton, did intend to reduce medical capture of the primary care market and introduce and fund more services to be delivered by nurses and other professionals. The idea was to encourage more health education and health promotion than doctors were currently providing. Importantly, Upton's Green and White paper was the first policy document to recognise that inadequate primary health care escalated the costs of secondary care services, and for this reason, to challenge the GP monopoly of the primary sector. The paper became the precursor for the deregulation of the sector and many of the changes later instituted under the Primary Health Care Strategy (Ministry of Health, 2001b).

However, due to escalating costs, state-owned and funded secondary care (and not primary care) became the focus for reform during the early 1990s in an effort to enhance efficiencies and improve access to specialist services and reduce waiting lists. Hospitals were restructured based on a competitive business model, with the purchase and delivery of health services explicitly separated. There was a requirement that public providers compete with private providers, as well as return a profit (Health Reforms Research Team, 2003).

These reforms were later 're-formed' in 1996 under a new Coalition government of National and New Zealand First parties and reflected a retreat from the market model. The 'for-profit' objective was removed as well as threats of privatisation (P. Barnett & Barnett, 1999). A greater emphasis was to be placed on monitoring health outcomes, especially in primary care, where there was little accountability (Gauld, 2001). While relieved of the requirement to return a profit to the shareholders (i.e. Cabinet), hospitals continued to bear the burden of debt as they sought to provide services at contract prices that failed to cover real costs. Rationalisation of the workforce and closing or downsizing services became the only options for reducing financial deficits.

During this period of neoliberal health reform, a variety of third-sector primary care centres were established with the support of state funding. The term 'third-sector' refers to the non-government, non-profit sector (Crampton, 1999). Māori, as disproportionately represented in areas of high deprivation (see Ajwani, Blakely, Robson, Tobias, & Bonne, 2003), sought greater autonomy over health care services and established iwi[15] based primary care initiatives in many sites around the country. The Ministry of Health was active in their support of these initiatives due to the "sustained failure of the state and private sector to provide freely accessible services for low-income populations, rural communities and Māori populations" (Crampton, Woodward, & Dowell, 2001, p. 12). Providing services of similar quality, restraint on profit distribution is the main difference between third-sector organisations and for-profit organisations (Crampton, 1999). Consistent with neoliberal practices, state support and finance for the

[15] Māori word for tribal

development of iwi-based primary care services encouraged Māori communities to take responsibility for health care problems and attended to the neoliberal concern about special-interest group capture by facilitating entry of this new competitor to the health care market. As well, the location of these services in the third-sector simultaneously withdrew the state from overt and direct control. That said, Foucault (in Lemke, 2000, p. 11), citing the example of non-government organisations, cautioned them as being not "a reduction of State sovereignty … but a displacement from formal to informal techniques of government and the appearance of new actors on the scene of government". Nonetheless, Crampton (1999, p. 15) viewed iwi-based non-government initiatives as "one of the principal successes" of the reforms. Spaces created for nurse practitioners in third-sector trusts are examined further in chapter ten.

The impact of a decade of neoliberal reforms on nurses in hospitals caused a massive shift in their representation as well as the normative culture of health care management and delivery. The effects of managerialism on nursing are described by Tilah (1996) as shifting the power of decision making from the original triumvirate management of hospitals to policy makers and planners without professional health affiliation. In contrast to the fragmented voice of nursing at the time (see chapter five), the medical profession fared reasonably well under the reforms, perhaps due to their solidarity and experience with resistance to government interference. The Employment Contracts Act (ECA) 1991 applied contract law to health care contexts because they, too, along with the economy, were now operating on a competitive basis. A representation of nursing as a unionised workforce is discussed further in chapter five. Suffice to say here, in addition to a dramatic effect on nurses' wages with the loss of award conditions (Blake, 1997; NZ Nurses Organisation, 1993 June), the New Zealand Nurses Organisation (NZNO) was rendered virtually powerless in contract negotiations on behalf of its members.

Consequently, nursing became an easy target for staffing cuts, which resulted in substantially increased adverse clinical outcome rates for hospitalised medical and surgical patients (see McCloskey & Diers, 2005). Connor (2004) describes nursing during that time as practising under a functionalist discourse, whereby the

drive to cut costs positioned nurses as responsive only to client functional deficits. The managerial perception then followed that nurses added value only when providing direct bedside care. Consequently, much of nurses' hierarchy in management, clinical leadership and education were lost to generic managers thought to be better placed to manage nurses than nurses themselves (Carryer, 2004).

In terms of power relationships having a "directly productive role wherever they come into play" (Foucault, 1990, p. 94), the consequence of managerialism 'writing' nursing was to produce a disaffected nursing workforce unable to provide efficient care without the support structures of clinical nursing leadership. Service provision contracts designed in a non-nursing management structure tended to circumscribe nursing practice, restricting innovative and effective intervention that fell outside the boundaries of the contracts.

However, it could equally be argued, as has Papps (1997, p. 278), that the health reforms of the 1990s disestablished the "ritualistic authoritarianism" of nursing hierarchies (examined further in chapter five) and positioned both nursing *and* medical staff in a subordinate position to general management. The official relationship between nursing and medical staff therefore became egalitarian and collegial and presented an opportunity for nurses to be free from the disciplinary techniques normally used by medicine to manage the doctor – nurse relationship. It could also be argued that the reforms opened up new spaces for a discourse of advanced practice nursing to develop, spurred on by the need for workforce retention strategies and solutions to address an almost flat career structure and lack of nursing leadership in clinical practice.

Third Way health reform

According to a number of commentators, the neoliberal health reforms of the 1990s were an experiment that had failed dismally (R. Barnett & Barnett, 2004; Easton, 1994; Gauld, 2001; Jesson, 1999; Kelsey, 1998). The incoming Labour government of 1999 subsequently initiated another round of health reforms based on election promises and refashioned the health sector to be non-competitive under the New Zealand Public Health and Disability Act, 2000.

Although key structural changes were made to the management of hospitals, this round of reforms impacted most on primary care. In conjunction with a number of over-arching health strategies set to central priorities, the New Zealand Public Health and Disability Act, 2000 made provision for the establishment of 21 District Health Boards (DHBs) that would own and manage the public hospitals, directly purchasing and providing de-centralised services for geographically defined populations. The Act aimed to reduce health disparities, to provide a community voice in health-sector decisions, and to promote the integration of all health services, especially primary with secondary services. Intent on tackling what was essentially a private primary care service, one of the over-arching strategies that support the Act, the PHC Strategy (Ministry of Health, 2001b), became the first government document to enact policy related to primary health care, despite a national and international discourse indicating its necessity since the 1970s. Primary health care nursing was identified as being crucial to the Strategy's implementation.

Modelled on the iwi-based primary care organisations that had flourished during the 1990s, and similar to Primary Health Trusts in the UK, the PHC Strategy provided for the establishment of community trusts called Primary Health Organisations (PHOs) to be funded by DHBs for the provision of services that met local needs (Ministry of Health, 2001b).

Although modelled on existing third-sector not-for-profit primary health care, where doctors and nurses are paid a salary (Crampton, 1999), in reality, the collective groupings of privately owned general medical practices known as Independent Practitioner Associations (IPAs) simply re-branded as PHOs and maintained their membership with the IPA Council. They employed a broader range of health professionals but in many cases took charge of governance, essentially continuing to operate as private businesses on public money (Morrissey, 2003). Resurfacing liberal notions seemingly embedded in medical discourse, many individual GPs continue to be paid a fee-for-service for each patient consultation rather than a salary (Kumar, 2004). Due to a growing trend amongst younger GPs away from the stresses of owning a medical business, one isolated and mostly rural DHB directly employs salaried GPs to staff the medical

centres it owns in the area (Powell, 2005, Feb 3). Nurses otherwise remain in the employ of the GP-owned practice and are paid a salary from the capitation funding pool. Discussed further in chapter eight, funding and employment structures in the IPA-type of PHO have constrained the expansion of nursing practice by limiting the clinical autonomy of nurses (Minto, 2006).

Notwithstanding the limitations of IPA focused PHOs, discourses of primary health care and the Third Way in the meantime have together played a productive role in expanding the autonomy of nursing practice (Affara, 1995). The philosophical congruence of nursing education with key primary health care principles is particularly salient (Carryer et al., 1999). With some notable exceptions, particularly in public health and in district nursing (see Arcus, 2004), traditional nursing practice had been confined to inside the hospital walls or general practice rooms, where nurses are always visible and subject to the gaze of medicine (Foucault, 1977a). However, the possibilities for PHC nursing go beyond the traditional surveillance or gaze and have led to consideration of ways to extend nursing's accepted roles.

In sum, two philosophically opposed positions have emerged in reference to the provision of health care: the *egalitarian* view congruent with the Alma Ata Declaration on Primary Health Care (1978) that regards access to health care to be the right of all citizens, connecting physical and mental well-being with *social* well-being; or the *market liberal* view that regards access to better quality health care to be part of society's reward system for those on higher incomes (T. Ashton, 1992). Health, to a market liberal, is a commodity to be bought and sold on the level playing field of its particular marketplace (Kelsey, 1998) and utilises the language of the market to position 'patients' as health care 'consumers'. Social justice discourses, on the other hand, associate the right of access to welfare with improved health status.

The tension between discourses of social welfarism and of neoliberalism has been, and still is, exemplified in the tension between the state and private general practice. On the one hand, the welfare state has sought to provide a free health service to New Zealand citizens, while on the other, promoted a free-market

approach to business. General practitioners, however, while endorsing in principle free access to their services via state payment, have resisted relinquishing the clinical and business autonomy implied by state provision, calling it in 1941 "a condition of state helotry" (Dr. Jamieson in Sutch, 1966, p. 242). Little has changed in the intervening years:

> There's a very fierce independence in general practice, and there's always a debate and a tension that goes on between – you know – government funding always comes with strings attached. And whether you want to take the subsidy with one hand, but actually put the noose around your neck with another is certainly something that the sector will look at carefully (Cathy O'Malley, Chief Executive of WIPA, in Graham, 2005, November 27).

Significantly, the tension between these discourses shapes the relationship medicine has with the state and with other health professionals such as nurses, and with the population. It has constructed health discursively as the expert province of medicine alone, entitled to the status, income and privilege such a representation merits.

Summary

The assumption of state responsibility for the provision of health services has been interpreted to greater or lesser extents within different truth regimes. Essentially, discourses of welfarism and the Third Way achieve many of the goals of neoliberalism by taking 'another way' or route via the enhancement of social health. Each of the discourses discussed structure health services in particular ways, employing legislative change as the means of implementation for respective regimes of truth. The population, as well as health practitioners, are made subject to these regimes and are expected to adjust their conduct accordingly.

Within a discourse of welfarism, health is constructed as the right of all citizens and funding practices are adjusted to ensure all members of society can afford medical care. In the post-war era of welfarism in New Zealand, these practices normalised health care towards consultation with a medical doctor when sick.

Medical discourse asserted the reciprocal right to charge a fee-for-service, thus normalising the fee-setting practices of physicians in private practice.

A neoliberal discourse constructs health within the context of the market, regarding health as a commodity and shifting responsibility for health to the individual. Neoliberal discourse continues to have currency in New Zealand, viewing individuals as solely responsible for the consequences of self-care, or lack thereof, and valuing those not entrenched in state welfare dependency (Brash, 2005). The intention to reduce medical capture of primary care led to a thriving third-sector non-profit primary care service; while practices of managerialism, profitability and competition, although undermining to traditional workplace practices, opened up new spaces into which nursing could potentially reposition itself.

The legitimacy and endurance of a Third Way political ideology in New Zealand is an argument best left to political scholars. Suffice to say, as a regime of truth it served to construct a health service re-focused on assisting people to realise their potential unimpeded by preventable disease or premature disability, or even death. Its articulation with a Primary Health Care discourse positioned the nursing workforce prominently within this objective, giving substance and framework to the gathering momentum of discussion towards an advanced practice role for nursing recommended in the Ministerial Taskforce on Nursing (1998). However, although there are signs that younger doctors entering general practice want change, general practitioners who continue to draw upon liberal and neoliberal discourses to ensure business viability constrain the possibilities for nurses to be positioned differently in primary health care. These constraints are examined further in chapter eight.

The following chapter considers the discourses internal to nursing and the construction of early, altruistic service representations of the nursing workforce, tracing the emergence of autonomy as an attribute of professional practice. The shifts in representation of nurses and nursing that occurred over the course of the 20th century are also examined.

Chapter 5: Political discourses inside nursing

Introduction

Foucault viewed the subject not as free and autonomous but as a *construct* produced by the broad relationships of power present everywhere (Mansfield, 2000). Positioned as subordinate in relation to a medical discourse, the nursing identity has been shaped by exclusionary and disciplinary practices (Foucault, 1977a) to construct a docile and useful role for nurses in New Zealand. The functional organisation of nursing services furthered this end.

The intention of this chapter is to foreground a discourse of autonomy and to contrast it with early nursing representations of the altruistic service ideals of the nursing workforce, as well as unionist representations, and finally by the end of the 20th century, new representations. Nursing autonomy has never been specifically banned in New Zealand as it was in the United States (see Safriet, 2002), but particular practices serve to contain it and remain present everywhere.

The official organisations representing the interests of nursing are traced in this chapter; specifically, the New Zealand Nurses' Association, the Nurses and Midwives Board, and the Division of Nursing in the Department of Health. I argue their alliance impeded the ability of nurses to practise with autonomy and, in concert with rapid advancements in medical technology, perpetuated a nursing workforce structurally ill-equipped for an increasingly complex medico-technological hospital environment. Political forces introducing the welfare state, and later neoliberal reform to the health sector, shifted a workforce represented as altruistic to one represented by unionist practices. The introduction of a clinical career path for nurses influenced by generic management principles and risk reduction practices is traced, but framed as yet another form of disciplinary technology in the form of the dossier (Foucault, 1977a). Clinical career paths, however, not only raised the possibility of the expert nurse, but also created an interstice for the notion of the *most* expert nurse, the nurse practitioner, to adolesce.

A range of interpretations of nursing in New Zealand in the 20th century have been produced, and a complete and progressive history in this thesis is not intended. While primary sources are utilised, so are a number of excellent secondary sources, mostly unpublished New Zealand theses (for example, K. F. Adams, 2003; French, 1998; Harding, 2005; Jacobs, 2005; K. F. Wilson, 1995). Towards the end of the chapter, excerpts of interview data are introduced to the analysis (this text is presented in italics) as participants made reference to the various events under consideration.

Representing nursing

Exclusionary techniques

Intended to advance the interests of trained nurses as well as public safety, the campaign for state-sanctioned systems of nursing registration at the turn of the last century marks the beginning of a professional project for nursing. According to Witz (1990, p. 675), "professional projects are essentially labour market strategies which aim for an occupational monopoly over the provision of certain skills and competencies in a market for services". A monopoly is achieved by various techniques and strategies chiefly belonging to the notion of occupational closure. Murphy (1984) describes two modes of closure based on Weberian theories, those of exclusion and usurpation. Exclusionary closure involves the downward exercise of power from one group to a subordinate, inferior and ineligible group, whereas usurpationary closure involves the exercise of power in an upward direction to take advantage of characteristics or practices belonging to that group. A strategy of closure occurred by Act of Parliament in the Nurses Registration Act, 1901, successfully excluding those without the appropriate knowledge and credentials from participation in the registered nursing profession.

One of the roles of the New Zealand Trained Nurses' Association (NZTNA[16]), after its inception in 1909 by Hester Maclean, was to maintain the exclusionary power established under the Nurses Registration Act, 1901 by safeguarding the

[16] The New Zealand Trained Nurses' Association later became the New Zealand Registered Nurses' Association in 1932, eventually dropped 'Registered' in 1971 (M. G. Smith & Shadbolt, 1984), and finally became the New Zealand Nurses Organisation in 1993 when it amalgamated with the National Nurses Union. Unless referring to a specific era, the generic 'Nurses' Association' is used.

professional monopoly of nursing. Techniques included accepting a qualified membership to the association only and including 'trained' in the association's name, which emphasised the difference between the qualified nurse and the unqualified. Furthermore, registered nurse members were expected to be "in good standing, and have a testimonial from a local matron" (M. G. Smith & Shadbolt, 1984, p. 3). Given that many untrained women worked to care for the sick in private homes (Maclean, 1932), and that nurses upon registration, being unable to find hospital work, left to take up private nursing (MacGregor, 1906), untrained women presented a threat to the livelihood of the trained nurse. A major preoccupation in the early years of the Association was therefore, to ensure employment preference was given to registered nurses both inside the hospital and out of it (Kinross, 1984b). The Act, at least, now provided doctors and other employers with a convenient list of qualified nurses from which to draw[17].

Techniques of exclusion were also manifest in the training of nurses, being the fourth objective of the NZTNA, specifically "to assist in maintaining a high standard of training throughout the Dominion" (Bicknell, 1908, p. 82). The 'high standard' began by ensuring the right kind of probationers were selected and served to ensure uneducated women from the lower classes, those without financial resources, married women, young women under the age of 23 years[18] (Nurses Registration Act, 1901, s. 4(3)), and men were all effectively barred from becoming registered nurses.

Many of these strictures related to the class of applicant and reflected the views held by a few influential nurses and their medical colleagues, who defined the registered nurse principally by what she was not. A concentration of power occurred as an effect of holding office across a number of closely related institutions, including the ability to circulate ideas nationally via a subscription

[17] Section 12 of the Act stated: "In all appointments of the nurses in hospitals under the control of Boards constituted under the 'Hospitals and Charitable Institutions Act, 1885', preference shall be given to registered nurses".
[18] Successive Nurses Registration Acts altered the required age for nurses at commencement. For example, the Nurses Registration Act, 1920, reduced the age of commencement from 21 years to 18 years.

publication[19]. It facilitated the dominant representation of nurses as a white, subservient, well-educated class of women, motivated by altruistic values rather than pecuniary gain. Thus, the construction of the registered nurse within the Department of Health (who administered the Act) was one and the same with that of the NZTNA. Furthermore, the subservience of nursing to medicine was paralleled in the secondary positions early nursing leaders held to their medical counterparts and of women to men in society in general. The close alliance between these institutions continued until such time as the regulation of nursing was separated from the Department of Health under the Nurses Act, 1971 (discussed later).

Other examples of exclusionary tactics can be found in discussions by McKegg (1992) and Holdaway (1993) of the discrimination around the time of the Nurses Registration Act, 1901 against young Māori women seeking entry as probationers in a hospital training school for nurses. Although the regulations did not stipulate a particular level of entry qualification, standard six, or eight years primary schooling, was considered the minimum (Rodgers, 1985), yet many Māori girls had left school by standard three (Holdaway, 1993). The Act required the age of registration to be twenty-three years, but very often by that time the responsibilities of marriage and motherhood precluded any possibility of entering nursing. These issues applied to Māori and lower class Pakeha[20] alike, but for Māori there were also hurdles of learning nursing in a second language. Institutional racism was evident too in the attitude of hospital officials (particularly matrons) who refused to have Māori women as probationers on the basis of race, and where they were accepted (Napier and Auckland), insisted on racially segregated living accommodation (McKegg, 1992). Having endured the hospital probationary period of three years, a pass in the state examination was still required and the one-pound fee to be paid for one's name to be entered on the register[21].

[19] Hester Maclean held concurrent roles as assistant Inspector of Hospitals, editor and owner of *Kai Tiaki*, President of the NZTNA, and later under the Health Act, 1920, Director, Division of Nursing in the Department of Health.
[20] Pakeha is a Māori word referring to a New Zealander of non-Māori descent
[21] Assuming a probationer were paid 5/- a week (Rodgers, 1985), one pound (20 shillings) amounts to one month's pay.

Beginning in 1898 and formalised by 1905, an Education Department scholarship scheme was instigated to address what had become desperate Māori health concerns. Māori women were trained to be registered nurses who would then return to their villages to teach cleanliness and proper sanitation (Dow, 1995; Holdaway, 1993; McKegg, 1992; Wood, 1992). The scheme languished for want of bureaucratic concern for Māori health, despite a legislative commitment to encourage Māori women to become hospital probationers in the Hospitals Bill, 1906. Under the scholarship scheme, one or two Māori girls each year were recruited from the elite Māori girls' colleges (so meeting the educational entry requirement), and this led, over the years, to a small number attaining registration. Most notable, perhaps, was the first Māori nurse to become registered, Akenehi Hei in 1908 (McKegg, 1992).

Another exclusionary tactic, explored more fully elsewhere (Dunsford, 1996; Harding, 2005; Papps, 1997; Rodgers, 1985), is the dominant discourse of gender in the construction of the registered nurse. This is apparent in the Nurses Registration Act, 1901, which refers to nurses in the feminine. There was an assumption at the time that only women, not men, would become registered nurses due to the gradual usurpation of the male nurse role by female nurses. Dr MacGregor described this in 1901, just prior to the introduction to the House of the Hospital Nurses Registration Bill, when he wrote:

> Formerly our hospitals were for the most part served by a mixed staff of male and female nurses. Gradually this has been 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 (MacGregor, 1901, p. 2).

Absent from the nursing records is any mention of male nurse attendants taken on as probationers in a training school prior to 1930 (Rodgers, 1985), although clearly they were working albeit in an untrained capacity (Harding, 2005). The exception is one man whose name was entered on the register in 1908 as G. A. Branstater, number 598. According to Beverly Chappell, he trained in the United States and worked in Christchurch ("Uncovering the stories," 2001).

The issue of 'male nurses' is not properly addressed in legislation until 1939, when an amendment to the Nurses and Midwives Registration Act, 1925 provided for a separate register for male nurses[22]: the Register of Nurses remained only for women. The Public Services Association, in their submission to the Social Services Committee on the Nurses Bill, 1971, challenged the 'registered male nurse' category as superfluous, stating it should be "dropped and the definition of a 'registered general nurse' should be broadened so that the expression is no longer confined to females" (p. 1). The separate category for men who were registered nurses changed in the Nurses Act, 1977 due to their acceptance into co-education with female students in comprehensive schools of nursing, first piloted in 1973 (Harding, 2003).

The construction of the registered nurse as female was a technique of occupational closure rarely achieved by women over men, yet was accomplished by tapping into the assumptions about women's work held by a higher class of men *and* women in influential positions within the government who determined the direction of legislation. A gender discourse therefore created a specific female representation of nursing that rendered another gender possibility for the registered nurse role to be inconceivable at the time.

The strictures of gender, race, class and education was important to the image of the trained registered nurse, who was a lady after the Nightingale tradition, of good social and moral standing, but who had endured an arduous training of discipline and long hours to be awarded the exclusive title of 'nurse' (Chua & Clegg, 1990). Although intended to advance nursing, these exclusionary tactics served to entrap nurses in the Victorian ideal (French, 1998) of the virtuous woman (Jacobs, 2005). The requirement for "good character and reputation" was not only a class-related Nightingale legacy, but later became a legislative requirement under the Nurses and Midwives Registration Act, 1925 (s.16(3)) and persisted through subsequent nursing enactments with the addition of "fit and proper" (Nurses Act, 1977, Part II, s.19a). It has now extended to all health

[22] Male nurses completed a two year training because "it was considered unnecessary for men to spend three years in training if they were not going to nurse women and children" (Lambie, 1956, p. 157).

professionals under the HPCA Act, 2003, described as "fitness to practise" (Part III) and "in good standing" (Part II, s.19.4c).

The dominant representation of a white, subservient, well-educated class of women successfully excluded undesirable influences from the nursing ranks and achieved an occupational *monopoly* but perversely conspired to create a docile worker intentionally constructed as subordinate to medicine. Kathryn Wilson (1998) contends that nursing participated in its own subjection by its willingness to practise in the shadow of medicine and by alignment with society's wider agenda for the role of women. A more visionary objective of occupational *autonomy* may have been achieved under a less conservative nursing leadership (see Rodgers, 1985).

Nurses as a workforce: docility-utility

Representations of nurses as a workforce were governed by practices that prioritised the labour requirements of institutions over the educational needs of probationers (French, 1998; Sargison, 2001). The disciplinary institution of the hospital acted like a machine for transforming and controlling nurses, imposing a relation of 'docility-utility': that is, a docile body that is both useful and productive (Foucault, 1977a). The apprenticeship model of training nurses ensured a ready supply of labour to undertake the menial and domestic tasks of nursing and was characterised by low wages, long hours, discipline and order, placing considerable emphasis on practical skills (K. F. Wilson, 1998). Annette Stevenson (1997, p. 44) points out "student nurses were cheaper and more easily available than domestic workers". Nursing work was hierarchically organised, with successive levels of senior nurses supervising the work of those more junior. Seniority was rewarded by less dirty menial tasks and more complex and medically derived nursing tasks (A. F. Stevenson, 1997; K. F. Wilson, 1998).

Power techniques of rank, space, time and motion produced the nurse as a cog in the hospital machine. One particular technique to control the activity of nurses occurred by the division of time, with the traditional timetable forbidding the wastage of time. The clock dictated the rituals and routines of nursing work: of medications, bathing, wound care, observations, turning, feeding, toileting and of

cleaning and shift work. Foucault's notion of discipline arranging for a 'positive economy' suggests that timetables served to crowd more and more activity into a day, with the ideal point being one of "maximum speed and maximum efficiency" (Foucault, 1977a, p. 154). The discipline imposed by time reinforces the docility of nurses as they are busied with the technical aspects of their work to the exclusion of possible autonomous thought or even meaningful patient interaction (Papps, 2001).

The dependence of the hospitals on student labour continued until the introduction of comprehensive nursing education in the 1970s and 80s. Significant student dropout rates of 30-44 percent (Dunsford, 1996; A. F. Stevenson, 1997) were attributed to many being 'unfit' to nurse. Unfit meant they did not like the work, were not strong enough, failed examinations, impropriety, were in ill-health or got married (McDougall, 1997). A *suitable* image of nursing therefore assumed greater importance than retention of an almost-registered workforce, and at the expense of nursing autonomy prioritised attributes of docility and obedience to the hospital regime. As a representation of nursing, misfits were expendable: for hospital administration, they were cheap to replace. An uncritical approach by nursing leaders to student losses (or 'wastage', and sometimes, 'matrimonial wastage' – see Dunsford, 1996) perpetuated the existing disciplinary practices of apprenticeship training and reproduced a registered workforce forged in the same furnace (Sargison, 2001). Student dropout was to remain an ongoing and highly problematic issue well into the 1960s and contributed to the review of nursing education by Carpenter in 1971 and its eventual relocation to the tertiary education sector (discussed further in chapter six).

The roots of the docile body can be found in the discipline of monasteries and armies (Foucault, 1977a) upon which nursing was founded. The requirement for all nurses, regardless of seniority, to live in the hospital-provided nurses' accommodation echoed those roots. The close proximity of living quarters to the hospital ensured the nurses' ready availability for duty in the wards: for example, "nurses were called from their sleep to complete the night shift and subsequently worked the following day" (Rodgers, 1985, p. 56). As a discursive practice, living-in positioned nurses as a workforce dependant and cared for by the state for

every aspect of life: for shelter, food, and family. As an extension of the hospital, the Nurses' Home systems of surveillance were an extension of the hospital's systems of surveillance and afforded continuity of control. For example, Rodgers described the supervisory jurisdiction of the most senior nurse, the hospital matron, as the "guardian of the nurses' professional and moral conduct" (p. 13), presiding over the nurses' training, leave requests and rosters, as well as the housing and leisure of the unmarried nurses. Forms of punishment for nonconformity tended to be censure, withdrawal of leave, or the addition of extra work (A. F. Stevenson, 1997) and were deployed as disciplinary technologies that forged a "subjected, used, transformed and improved" docile body (Foucault, 1977a, p. 136) of nurses.

Living-in required that nurses remain chaste and as such were free from the burdens of childcare and wifely duties. Foucault (1990) theorised on the reduction of the expression of sexuality to its necessary minimum for reproducing the species and asked: "At a time when labour capacity was being systematically exploited, how could this [sexual] capacity be allowed to dissipate itself in pleasurable pursuits …?" (p. 6). The intense imperative for nurses to work was incompatible with the pursuit of sex and the encumbrances subsequent to its indulgence. Thus nursing as a vocation became a stopgap measure to marriage for many (L. Hughes, 1990) or an alternative career to marriage for others. The benefit to the Department of Health, charged with oversight of state hospitals, was a flexible and cheap workforce able to move around the country as needs required: accommodation was always at the ready and the nurse was free of the encumbrance of family or of property ownership.

Not only in rank and time are nurses inscribed as docile bodies, but by virtue of their location in the 'space' of the hospital and curative setting, they are always visible and subject to the gaze of medicine. Originally introduced to the House of Representatives as the *Hospital* Nurses Registration Bill, the Nurses Registration Act 1901 and subsequent legislation approved the training of probationers leading to registration in public hospitals only and actually referred to the nurse as "the sick-nurse" (MacGregor, 1906, p. 2). As Rodgers (1985) points out, state registration was a source of power that controlled the location and method of

nurse training and so controlled the direction of nursing knowledge. Under the careful instruction of the matron and medical officer, the hospital location of training ensured nurses were oriented to caring for sick people who had been admitted under the care of a physician. Thus, not only was a probationer's learning based around medical specialties, it was also in accordance with bio-medical understandings of cure. Doctors delivered the majority of required lectures on body systems and associated diseases and set the written examinations[23], while the matron instructed on the practical skills of nursing care.

Strict obedience to medical instructions was absolutely necessary but conveyed the notion that the doctor worked through the nurse as if she were the doctor's hands, being incapable of autonomous action (Chiarella, 2002). Thus, a medical technology of domination defined and controlled "the conduct of nurses submitting them, through the exercise of power, to useful and docile roles" (Papps, 2001, p. 10). Representations of domesticity and of the handmaiden reinforced the nurses' subordinate position to medicine, as did the acceptance of delegated routine tasks and allowed the professional domain of medicine to expand (H. Gardner & McCoppin, 1986).

Two world wars and the introduction of the welfare state, along with the public expectation of 'free' hospital care (see chapter four), brought about considerable sophistication in surgical and medical techniques, requiring nursing knowledge to follow those trends. The introduction of new supporting technologies such as laboratories, X-ray machines, blood transfusions, intravenous fluids and antibiotics[24] also increased the demand for a cheap nursing force to care for the increasing numbers of hospitalised patients. As a consequence, apprenticeship training for nurses remained firmly within the hospitals (Rodgers, 1985) and continued well into the 1980s. Although the association of nursing with hospitals and medical technology created the opportunity to develop technical skills with

[23] Doctors set the state nursing examinations until such time as the Nurses and Midwives Board took over the responsibility under the Nurses and Midwives Registration Act, 1925. French (1998) notes the medical profession continued to write and mark the state nursing examination until 1937, and as recently as 1984, medical consultants were still involved.
[24] For greater detail concerning these developments, see A. F. Stevenson, 1997.

more sophistication than the Nightingale emphasis of 'nursing the room', it also reinforced nursing's dependence on medical direction.

Because nurses were constructed as "objects to be molded, not subjects to be heard" (Dreyfus & Rabinow, 1983, p. 154), their individuality was overridden by the concern for a conforming and uniform hospital workforce. Opportunity for advancement offered to nurses came by way of a 'shoulder tap' to attend the prestigious post-graduate school in Wellington (A. F. Stevenson, 1997). The school arose out of a failed attempt in 1925 to establish a diploma at the University of Otago for both basic[25] and post-basic preparation of nurses – details of which have been documented by Beryl Hughes (1978) and Jan Rodgers (1985). Suffice to say that despite an all-out campaign by the Otago Section of the NZTNA to make a success of it, the tutors sent to Leeds and Toronto for extra training (Janet Moore and Mary Lambie) returned not to establish the diploma at Otago University as expected but to set up the post-graduate school for nurses (later named SANS[26]). The school fell well short, however, of the vision for a university-educated nurse and as Rodgers (1985) concludes, reinforced the fact that "worthy aspirants to leadership positions in nursing came by way of the apprenticeship training and any desire for higher education was by way of post-basic education for those tried and tested members of nursing" (p. 101).

The notion of educating nurses in the university represents a discursive shift in focus from nurses who were trained to be a docile and useful workforce towards the emergence of a discourse that constructed nursing as a professional, academic and autonomous discipline. Techniques to control the location and method of post-registration education, however, were successfully deployed to curb a workforce that could potentially compete with medicine for clientele and prestige. Locating nursing education as a discipline within the university would introduce a scholarly discourse into nursing and induce a relation of power unseemly to the

[25] Only two nurses were to graduate with a Diploma in Nursing from Otago University: Misses Frazer and Hillary (Rodgers, 1985).

[26] "The New Zealand Post-graduate School for Nurses has been renamed the New Zealand School of Advanced Nursing Studies (SANS). Confusion has arisen overseas from the word 'graduate', said Mrs. Shirley Bohm, Director of Nursing at the Health Department. The School offers courses to qualified nurses, who are not necessarily graduates of a university... and [is] headed by the principal, Miss E. Beatrice Salmon" ("School's new title," 1970, p. 20).

ladylike ideal of helpmeet to medicine. Furthermore, a university-prepared nurse would undermine not only the ready supply of apprenticed labour, but also threaten the existing indoctrination mechanisms that controlled nurses and nursing. These same arguments – including that of cost – were repeated when nursing education was moved to the tertiary education sector in the 1970s. The threat of higher education to the institution of nursing and its associated cost, was then recapitulated in the nurse practitioner debate in the late 1990s.

Discursive practices governed the apprenticeship of nurses, selection criteria, living arrangements, uniforms, leave entitlements, rosters, off-duty behaviour, employment practices, teaching practices and examination practices: all conspired to repress nurses' individuality, in addition to any propensity to practise with autonomy. Autonomous practice was thus constructed as deviant from the traditional nursing role of helpmeet to medicine, and was controlled by normalising techniques that paralleled those of women to men in society at large.

Representing nurses

This next section traces the transformation of a docile nursing workforce into an organised workforce shaped by practices associated with the Trade Union movement. Industrial representation for nurses brought about a change of power relations with the state, employer and the public and importantly, reversed the dependence of nurses on the state to be deployed in the interests of the institution. However, the development of collective worker rights did little to enhance the autonomy of nursing practice due to the conflicting subjectivities each of these discourses creates: where autonomy articulates with higher education, it constructs an innovative and non-conforming individual; where unionism articulates with social-democratic political ideals, it privileges collective employee processes that construct a homogenous workforce. The perceived preoccupation of the NZNA with industrial practices in the late 1980s was resisted by an emerging academic discourse that privileged scholarly enquiry and professional autonomy and led to the separate establishment of multiple specialist organisations, most notably, the College of Nurses Aotearoa in 1992.

In the sense that the Nurses' Association represented the professional interests of nursing by engaging in practices of consultation with its members, surveillance of training programmes and political lobbying, this section refers to a discourse of representation of *nursing*. This is distinct from a discourse of representation of *nurses*, which refers to the union practices of industrial action, wage negotiation, conditions of employment and dispute resolution between employers and nurse employees that were engaged in officially since the Nurses' Association was first recognised as an employee organisation in 1947 (Hatherley, 1989). By distinguishing between discourses that represent nurses and those that represent nursing, the history of nursing leaders who have struggled to reconcile these oftentimes conflicting discourses is acknowledged. Some of these leaders have despised the involvement of nursing in unionism (Maclean, 1909; Storey, 1983), while others have viewed them as inextricably linked (Carey, 1984).

Reflecting the earlier constructions of nursing as an altruistic and docile workforce, Hester Maclean wrote a strong warning against nurses becoming embroiled in the industrial disputes that characterised the first decades of the 20th century in New Zealand (for example, the Blackball Miners strike of 1908) and led to the formation of the Labour party:

> We must, however, guard against any elements of trade unionism creeping in among us. A nurse must be a woman, working, not in the first place for the sake of money-making, but for the good of her fellow creatures to alleviate suffering when she can and help towards health for those who need her care. In doing this she may legitimately look forward to earning her living in the way in which her natural instincts lead her (Maclean, 1909, p. 77).

Maclean was likely prompted to write this warning because of the Hospital Bill before the House of Representatives that year, which would have made compulsory an eight-hour day for all nurses ("Hospitals Bill," 1909). Indeed, Sargison (2001) suggests it was this proposal that prompted Maclean to found the New Zealand Trained Nurses' Association in 1909 against "this serious danger to nursing work" (p. 178). She considered the steps taken by the Association to protest this action to have been most important and was pleased "this protest

succeeded in limiting the legislation to uncertified nurses in training and really left matters practically as they were" (Maclean, 1932, p. 69). The clause in the Bill was eventually modified, making compulsory a 56-hour (seven day) week for pupil nurses working in hospitals of over 100 beds, but it did not apply to those already trained who continued to work longer hours.

These hours of work remained unchanged until 1931 (Pitts, 1984) and as labour practices, exploited the altruistic aspirations of nurses: it was not unusual in some hospitals in New Zealand in the 1920s "to work a year after commencing nursing without a day off for either sickness or leave" (Rodgers, 1985, p. 56). Rodgers, Dunsford (1996) and Stevenson (1997) noted probationers often worked longer than the prescribed eight-hour day, a situation that continued well into the 1970s:

> In the early 1970s when I trained at Wellington Hospital, student nurses may have been rostered to work a morning shift, for example, from 7 am to 3.30 pm, but in some wards we began work half an hour or more earlier and finished late because you went home when the work was done not because the shift was over. In a ward of 40 beds, with one staff nurse and three students, everyone was showered or sponged and it took that long to do the work. In my first year we worked six days, but after that it changed to five (Jean Gilmour, personal communication, May 9, 2006).

That nursing leaders endorsed these working conditions illustrates an understanding of nurses as altruistic and dutiful servants that was consistent with the professional workforce image portrayed at the time to the public and valued by medicine. This is not to say that the Nurses' Association was unconcerned with the working conditions of nurses, but improving the lot of the nurse was not to be at the expense of compromising its professional objectives (Carey, 1984). Much of the Association's early efforts had centred on a superannuation scheme that nurses would benefit from once they left the workforce – the irony of which is noted by Carey (1984).

Elected in 1935 on a social democratic platform, within a year of the first Labour government taking office and with the support of the trade unions, compulsory unionism was introduced for all workers be they industrial or professional (B. M.

Brown, 1966). The government's social security measures and expanded hospital system reinforced the construction of nurses as a workforce as the demand for nurses dramatically increased. At a time when nurses were in a strong position to negotiate for improved wages and working conditions, talk of union activities was met with considerable ambivalence within the Nurses' Association. The socio-economic welfare and working conditions of nurses had always been a concern for the Association in line with the International Council of Nurses (ICN) and fear of being taken over by another union led to reluctant involvement in direct salary determinations for nurses without it actually registering as a trade union (Carey, 1984). Eventually, by 1947, the government had "officially recognised the Association as the organisation to represent and negotiate for nurses' salaries and conditions" (Hatherley, 1989, p. 2). The first Economic Welfare Committee was formed in 1955, appointing an Economic Welfare Advisor in 1963. The committee formed the basis of the industrial arm of the Association, joining the Combined State Unions in 1969 and the Council of Trade Unions in 1985. Finally, the State Sector Act, 1988 required the Association to register as a union under the Labour Relations Act, 1987.

By now, nurses were represented in industrial terms as workers with rights and replaced the representation of altruistic nursing service to patients. Acknowledging their contract with society, nurses demanded "a concomitant obligation not to exploit this commitment" with unfair working conditions (Cowie, 1987, p. 7). For the first time ever, nurses marched on parliament in 1985 and contemplated strike action due to nursing shortages and pay rates and actually withdrew services in March 1988 in protest to the State Sector Bill[27] (Hatherley, 1989).

A change of government in 1990 led to the introduction of the Employment Contracts Act (ECA), 1991 and significantly impacted on the Nurses' Association. It is easy to overlook the ECA's influence, given that the

[27] The State Sector Act came into effect on 1 April 1989. The Act established hospital and area health boards as individual employing authorities, and introduced general management principles to the health sector (Department of Health, 1989) and many senior nurses were made redundant. The private sector model of worker-management division was adopted under the Act for the State Sector, removing those earning over $50,000 from award coverage and placing them on individual contracts (B. Smith, 1998).

Employment Relations Act, 2000 has now superseded it. Reflecting the neoliberal discourse of the National government, the ECA abolished all compulsory unionism and union rights, destabilising the power of trade unions across the country and shifting the balance of power significantly in favour of employers. There was a dramatic effect on the nursing workforce in terms of wages and the loss of award conditions. Entitlements were lost, such as two consecutive days off; a nine-hour break between shifts; an eight-hour working day. Annual, sick, family and bereavement entitlements were reduced; and in some cases, meal, on-call, in charge, uniform and penalty rates were removed (Blake, 1997; NZ Nurses Organisation, 1993 June).

Driven by a free-market ideology (discussed in chapter four) the ECA was criticised throughout the 1990s by colleagues of the Business Round Table as not going far enough (Baird, 1996). The application of contract law to employment relationships, the removal of good faith bargaining and the belief employees have bargaining power on an equal footing to employers, were all principles that applied to health care contexts because they, too, along with the economy, were now operating on a competitive basis. The ECA positioned nurses as free agents in a competitive labour market, ostensibly allowing them greater freedom and choice of employer and contract conditions. In reality, the inherent imbalance of power between employer and employee, which the Act specifically denied existed, forced the NZNA to retrench and focus on restoring the hard-won rights nurses had earlier benefited from. Certainly the cooperative and influential relationship with the state that the Nurses' Association had enjoyed thirty years earlier had deteriorated sufficiently for the Minister of Health in 1998 to comment in the House: "I commend the nursing groups, *including the New Zealand Nurses Organisation, which, traditionally, has not been any friend of the Government*, on taking a constructive approach" (Hon. Bill English in New Zealand Parliamentary Debates, 1998, March 4, in reply to a question about the Ministerial Taskforce on Nursing, italics added).

Increasing immersion of the NZNA in industrial issues related to the health reforms and the ECA 1991 appeared to some nurses to be unsatisfactory management of both dual industrial and professional roles. This point was made

to the NZNA in 1991 by visiting NERF scholar, Ginette Rodger, who commented in *Kai Tiaki* on the perceived lack of professional nursing leadership in this country and the "vacuum in the healthcare structure felt by nurses" (Stodart, 1991, p. 13). Despite the NZNA's recognition of increasing specialisation in nursing as it developed special interest sections, efforts to reassure its members that the NZNA could and did represent both industrial and professional roles (NZ Nurses' Association, 1991a) were insufficient to meet the needs of some nursing groups and led to the separation and establishment of multiple independent specialist organisations (N. R. Allen, 1992).[28,29].

A small group of nurse academics known as the *Praxis* group had become increasingly frustrated with the NZNA's refusal to publish academic work in the Association's official journal, *Kai Tiaki.* Positioned by an academic discourse, this group established a new scholarly nursing journal called *Nursing Praxis in New Zealand* in 1985. They subsequently went on to form a new nurses professional organisation, the College of Nurses Aotearoa, in November 1992 with a membership comprising mostly nurse executives, educators and academics (K. F. Adams, 2003). The College concerned itself with influencing policy and legislation related to nursing and the health of the community and has deliberately not engaged in industrial negotiation on behalf of its members.

Despite the existence of many other independent specialist nursing groups, prior to the advent of the College of Nurses, professional and industrial issues had lain unquestionably within the domain of the NZNA. Whether intended or unintended, consequences of the formation of the College of Nurses were to create a competing organisation to the NZNA that served to divide nurses working in practice from nurses in academia and management. It reinforced the perception of a theory – practice gap persistently referred to in the international nursing literature. The organisational title 'College' carries connotations that privilege

[28] For example, the College of Midwives formed in 1989, the National Māori Council of Nurses in 1983, the New Zealand Occupational Health Nurses' Association in 1973, the Samoan Nurses' Association in 1990, and Nurse Educators in the Tertiary Sector (NETS) in 1992.
[29] Nurse Executives New Zealand had been in existence since 1927 as the Council of Hospital Matrons, followed by the Hospital Matrons Association, the Principal Nurses' Association, and the Chief Nurses' Association (K. F. Adams, 2003), reflecting the shift in naming practices that occurred over time.

knowledge backed by the authority of the academy. It stands in contrast to the clinical groups established by the NZNO that privilege the voice of everyday clinical experience. Although intended to be collaborative, fundamental differences in philosophy over industrial issues, the enrolled nurse role and post-graduate education have led to nursing representation being, at times, multiple and fragmented, when a unified voice would have been immensely more productive for nursing politics in New Zealand. A public example of the contest between the two organisations occurred over the Ministerial Taskforce on Nursing in 1998, discussed in chapter seven.

Fractured representations

Not only did the recognised and singular "voice" of nursing (NZ Nurses' Association, 1976, p. 36) fragment into multiple voices, but the official structures of the Nurses and Midwives Board and the Division of Nursing within the Department of Health also fragmented. Historically affiliated with the Nurses' Association, each had reinforced a representation of nursing as a docile and useful workforce consistent with its own objectives: to promote the ideal helpmeet for medicine; and to ensure a cheap and plentiful supply of competent nurses to staff the nation's hospitals. In concert with the introduction of trade union practices, the consequence of the Nurses Act, 1971 was to shift the earlier singular representation of nursing towards multiple discursive constructions.

In 1925, the Nurses and Midwives Registration Act established a Nurses and Midwives Board separate from the Division of Nursing to be responsible for the regulation of nursing. The Board was chaired by the Director-General of Health and included another medical practitioner member and the Director, Division of Nursing as registrar. The intention was for nurses to hold a majority on the Board and as non-nursing members were added with subsequent amendments (for example, a member of the Hospitals Association), so were the number of NZNA nominees. The taken-for-granted position of medicine in the regulation of nursing remained until 2001 and occurred in a spirit of teamwork, common goals and collaboration (Wood & Papps, 2001). However, it could equally be read as medicine maintaining a controlling interest in the affairs of nursing and censoring its autonomy, particularly as the Chair was given a casting vote. Note also that a

reciprocal courtesy was not extended to a nursing presence on the Medical Council. Given the potential for nurses in this pre-antibiotic era to compete with doctors for patients, particularly in private homes, Witz (1990) aptly puts the role of medicine in the shaping of nursing as not unlike the spider legislating for the fly.

There was little change in the make-up, conduct and business of the Nurses and Midwives Board until the 1971 Nurses Act. The Nurses' Association had maintained close links with the Health Department and the Board, forming a tripartite alliance that had exclusive control over all aspects of the nursing and midwifery workforce in New Zealand by uniting the regulation and education of nursing with its professional body. It held considerable influence in the political activities of nursing, due to the "officers of the Association and the nurses in the Department of Health [being] one and the same" (Kinross, 1984b, p. 95). For example, the Director, Division of Nursing within the Department of Health, was Registrar of the Nurses and Midwives Board and was also actively involved in the NZNA. On the one hand, this grouping successfully furthered mutual political concerns, but on the other, it contributed to a system of governance that was complicated by conflicting professional, industrial and state interests.

The intention of the Nurses Act 1971 was to disrupt the long-held tripartite alliance and shift state regulation to professional self-regulation by replacing the Nurses and Midwives Board with the New Zealand Nursing Council. As noted in the introduction of the Nurses Bill to the House of Representatives by the Minister of Health, the Hon. D. N. McKay, its purpose included:

> The loosening of the ties between the Government, operating through the Department of Health and the controlling authority of the nursing profession will enable the council to operate on a more independent basis than the present Nurses and Midwives Board does (New Zealand Parliamentary Debates, 1971, November 26, p. 4954).

Similarly, the Nurses' Association was freed of the Department constraints to pursue its professional and industrial goals. Its submission to the Social Services Committee on the Nurses Bill stated: "It has long been the Association's view that

the Board should be as independent as possible, therefore provisions in the Bill to make the Nursing Council more autonomous than the existing Board is seen as an important development" (Burton, 1971, p. 2).

In addition to its role as the statutory registration authority, the Nursing Council took over responsibility from the Department of Health for nursing and midwifery education. The new legislation, therefore, separated the Council from the jurisdiction of the Department of Health and formed new ties with the Department of Education, but also interrupted the ties between nursing regulation and education and the NZNA. For some time, however, little changed as NZNA influence remained on the new twelve-member Council because of the six NZNA nominees provided for under the Act, all of whom were senior nurses heavily involved with the NZNA leadership[30].

Foucault's (1990) 'rule of immanence' suggests disinterested knowledge does not exist and applied in this context, Nursing Council members, having knowledge of both Council and NZNA business, were powerfully positioned to resist interruption to the networks established under the old regime. Even so, the position of strength the NZNA held within the Nursing Council was thought insufficient and an unsuccessful submission to the Social Services Committee on the Nurses Bill, 1977 suggested an additional Council member, the Association's Executive Director, should also be appointed (Carey, 1977).

Absent from the constitution of the Council was representation by the New Zealand Public Service Association – a point made to the House on the third reading of the Nurses Bill, 1971 (MP for Palmerston North, Mr. Walding in New Zealand Parliamentary Debates, 1971, December 3). Making it clear that union representation was undesirable on the Council, the Minister of Health, Hon. D. N. McKay, preferred NZNA nominees who represented professional matters[31] (New

[30] For example, Chairperson of the Nursing Council from 1975 to 1984, Anne Nightingale, was also a member of the NZNA Council and President of the Auckland NZNA Branch during that period (Wood & Papps, 2001).

[31] Minister of Health, Hon. D. N. McKay: "The Public Service Association represents psychiatric nurses at present, but that is in regard to wages and conditions of employment. The association does not necessarily or to any great extent represent them on professional matters" (New Zealand Parliamentary Debates, 1971, December 3, p. 5069).

Zealand Parliamentary Debates, 1971, December 3). However, by 1977 the union activities of the NZNA were being more formally recognised, reflected in part by the Department of Health's response to the NZNA's proposal for another Council member: "The Department considers that the Executive Officer of the Nurses' Association, an official paid to promote the interests of the Association, would have difficulty divorcing himself from this 'trade-union' type of interest" (Department of Health, 1977, p. 12).

Increasingly, dual discourses of unionism and professionalism were entwining to construct an understanding of the NZNA's approach to professional representation that considered the two interests inseparable. As senior nurses shifted allegiance from the Nurses' Association to the College of Nurses following its establishment in 1992, the NZNO leadership shifted from senior nurses and educators to staff nurses in clinical practice (in "Work in progress," 1999), thereby constructing a division in the representation of nursing interests across these organisations. These factors and the constitution of the Nursing Council, were to have considerable influence on the Ministerial Taskforce on Nursing 1998, discussed in chapter seven.

Due to the major changes occurring in health services, the Department of Health underwent restructuring in December 1988 following the necessary legislative change to the Health Act, 1956 (Labour Relations Act, 1987). Although a chief nursing advisor remained, the loss of a Division of Nursing in the Department of Health lessened the strength of nursing representation in an increasingly medicalised department:

> *And it's not easy for [the chief nursing advisor] working in an environment that is still dominated by doctors and she has been a little island there and certainly I've supported her and the DG's [Director General of Health] supported her too actually. But she still works in an environment that is medically dominated (Senior Politician[1], p. 2 - 3).*

Further to the isolation of nurses in the Department, another participant interviewed for the study remembers the invisibility of her role as a nurse when she worked there:

> *I started off when I was employed in the Ministry in 1992 and I wasn't employed as a nurse, I was employed as, I think I was a policy manager at that stage … they didn't know I was a nurse (NCNZ[1], p. 1).*

The Nurses Act, 1971 therefore marked a separation and a change in the joint representation of nursing by the Division of Nursing, the Nurses and Midwives Board/Nursing Council and the NZNA. The focus of these bodies shifted so that each placed a different emphasis on how nursing was represented. The Department of Health shifted towards a policy role, particularly around workforce planning and represented nurses as agents of the state; the Nursing Council, under the Act, was responsible for nursing education and regulation and represented nursing as competent practitioners within the regulatory framework; and, as the NZNA became more involved in union activities, it represented nurses as workers with employment rights but maintained a separate arm to simultaneously represent professional and extended nursing practice.

New representations of nursing

It would be fair to say that particular representations of nursing have led to the autonomy of nursing practice to be repressed and the discussion thus far, although more fully explicated elsewhere, demonstrates this to be a historical fact. Writing of sex (and I of autonomy), Foucault (1990, p. 78) asks: "What is this force that so long reduced it to silence and has only recently relaxed its hold somewhat, allowing us to question it perhaps, but always in the context of and through its repression?" To consider the question of *extended* nursing roles towards greater autonomy as this next section does is to do just as Foucault observes. Nursing is in the first instance, repressed, and, it must be discussed from that context. The forces of gender, medicine and apprenticeship have been examined and it is now timely to study the forces that support and enhance nursing autonomy: to argue that all nurses at all times have practised under this burden is to deny the existence of a history of autonomous nursing practice. There are many examples of unauthorised discourses of nursing autonomy that took place outside the confines of hospital walls in the rural back-blocks (McKillop, 1995) and in patients' homes (Arcus, 2004) – beyond the gaze of medicine – where nurses "had more latitude in carrying out physicians' orders" (Peter, 2002, p. 70). New representations

discontinuous with previous constructions were afoot, however, and involved a relaxation of the hold on traditional subjectivities that had characterised nursing practice as dependent.

The turn in official discourse towards extended nursing roles gained in momentum subsequent to the Carpenter (1971) and associated reports (Department of Health, 1969; Department of Education, 1972; Reid, 1965b) discussed in chapter six, which identified a certain deficiency in the preparation of nurses for caring in an increasingly complex medico-technological environment[32]. Reflecting a shift in knowledge that had its basis in tradition, nursing knowledge was beginning to be based on nursing theory and research.

A survey of job satisfaction and motivation of New Zealand nurses[33] formed the basis of the 1974 report by the Committee on Nursing Services[34] *An improved system of nursing services in New Zealand* (Board of Health, 1974). It called for a "wholesale reappraisal" (p. 22) of the attitudes amongst nurses that were preventing the necessary development in knowledge and skill required "to match the demand of an expanding comprehensive health service" (p. 15). The committee noted the introduction of married nurses returning to the workforce on a part-time basis, the inclusion of men in the nursing workforce, and the surrender of non-clinical duties to clerical, messenger and housekeeping services had been difficult to accept. There was increasing demand for nurses to work outside the hospital in the community, but nurses had inadequate preparation under the apprenticeship model to do this. The committee was critical of the educational ill-preparedness of nursing leadership to plan effectively for the future extension of nursing services "away from sickness and hospital care to health care in the community" (p. 30). Challenging the disciplinary practices that constructed the nurse as "myths and rituals" (p. 24) and "outmoded traditions" (p. 22), the committee stated:

[32] Specialised units were introduced, such as intensive care, coronary care, burns facilities, and recovery wards; also machinery such as ventilators and monitoring equipment.
[33] The survey on nurses' job satisfaction was conducted by George Hines, 1974.
[34] The committee membership comprised two doctors, a business lecturer, deputy chief executive, and three senior nurses (Margaret Bazely, then Principal Nurse at Sunnyside Hospital; Shirley Bohm, Director, Division of Nursing; and E. Millar, Matron-in-Chief at Auckland Hospital Board), as well as six nurses (five of whom practised in the community) nominated by the NZNA, who participated in a one-day meeting.

> There is nothing inherent in nursing which requires nurses to live in a special place, be addressed by special titles (other than their names), or wear special uniforms except when providing direct care for some patients (p. 22)… People require individualised services rather than an assembly line of like tasks for all people (p. 23).

Anticipating the loss of a student nurse workforce to tertiary education settings, the report maximised the "responsibility, authority and accountability" (Board of Health, 1974, p. 37) of qualified nurses for the planning, implementation and evaluation of nursing care they delivered. This introduction of autonomous registered nurse practice was a considerable departure from the way tasks had traditionally been delegated to the student nurse ranks.

A 'model' reorganisation of nursing services that provided an "adequate career structure" (Board of Health, 1974, p. 59) was proposed and would promote job satisfaction and attract trained nurses back to nursing. Nan Kinross (1975, p. 23) draws attention to the exciting possibilities "tactfully placed in Appendix IX" of the report. Therein lies a series of nursing positions recommended to govern the delivery of nursing services both inside the hospital and outside in the community. Of note to this discussion is the 'Nurse Specialist' title, which:

> should be reserved for nurses of advanced education, clinical competence, and judgment who are capable of supervising the work of qualified nurses. This position is one of clinical management in a specialised area of nursing either outside or within hospitals (Board of Health, 1974, p. 60).

Dialogue between the NZNA and New Zealand Medical Association (NZMA) about the potential for extending nurses' roles was recommended and later in 1975, authorisation was sought by the NZNA of the Director-General of Health to allow experimentation with senior nursing positions, as well as that of 'clinical nurse specialist' (M. G. Smith & Shadbolt, 1984).

The inertia inherent in traditionally organised nursing services was perhaps too overwhelming for them to respond with speed to the challenges contained in the report, but pressure emanating from individual practitioners and from influential

positions eventually came to bear. In a study commissioned by the NZNA, the experience of 59 NZ nurses[35] who considered themselves to be independent nurse practitioners was explored via a questionnaire by Laura Hawkins (1989). Among issues identified by these nurses were appropriate remuneration and, of critical importance, "being able to act directly rather than through or for General Practitioners" (p. 22) and to practise with autonomy. These nurses welcomed the NZNA-initiated workshops and discussions with the Minister of Health about the suggested introduction of nurse prescribing authority (Williams, 1992).

Despite the absence of legal restrictions on practice (aside from prescriptive authority) discursive practices such as funding stream allocation functionally limited the advancement of autonomous nursing practice. Efforts to counter nursing's repressed autonomy were hindered by a "predilection in policy makers to perceive nurses in subservient roles to doctors which blinds them to the possibilities of nurses being more effective and efficient health providers" (Messervy, 1992, p. 224). A practising independent nurse practitioner, Lynn Messervy accused the state of creating restrictive trade practices through subsidies to some health providers and fostering the gate-keeping role of general practitioners through the restriction of referral rights to specialists, prescriptions, laboratory services, X-ray and ACC reimbursement. These concerns were acknowledged by Simon Upton in the Green and White Paper on government health policy (1991), no doubt because they ran contrary to the neoliberal laissez-faire economic principles of the government at the time, who wanted to improve consumer choice with a more free-market approach to the provision of health services. Despite a change of government and a freeing up of referral privileges to nurse practitioners between 2001 and 2005, many of the attitudes of bureaucrats towards nurses in general and described by Messervy remain.

From calling to career

Where once nurses were 'called' to nurse, or where nursing had served as a stopgap measure to marriage, a shift towards nursing as a career occurred as women began to choose to remain in paid employment for as long as they wished. Changing societal expectations for women, as well as the introduction of a

[35] 11 participants were domiciliary midwives.

Bachelor of Nursing degree, were instrumental in this shift. The entry of clinical career paths[36] into nursing discourse reflected this shift in both name and intent.

Formal and professional acknowledgment of varying levels of practice arose from a discourse that has its roots in managerialism. Seeking to manage risk, quality assurance processes introduced practices of credentialing, accrediting and certificating to individuals, programmes, institutions and products in order to assure employers and consumers of the 'quality' service they were getting (International Council of Nurses, n.d.). Credentialing processes were introduced by the NZNO to recognise individual nurses who met particular agreed standards[37] and echoed a career pattern for nursing first proposed by the NZNA in 1976, which recommended a clinical stream along which registered nurses could progress in seniority. Each level of seniority stipulated post-basic education and dovetailed with the later NZNA developments in credentialing. Nurse Clinician and Nurse Consultant levels were described in 1976 as 'extended' and attempted to bridge hospital and community boundaries by working between the two.

Successive discussion documents were produced by the NZNA on clinical career pathways (1984, 1987, 1991b), the last of which proposed a 'Level 5' nurse, which bore many similarities to the final description for the nurse practitioner scope of practice under the HPCA Act, 2003. It included the requirement for Level 5 nurses to be involved in research, policy and clinical leadership and to be masters prepared. At the time this proposal was written, perhaps forty nurses in NZ had a masters degree (NZ Nursing Council, 2000).

[36] More correctly termed Levels of Practice Programmes (LOPPs), structures that recognise differential and advancing levels of nurses' practice are also called clinical career pathways (CCPs) or, more recently, professional development recognition programmes (PDRP) (Trim, 2001).

[37] The NZNO offers two levels of voluntary credentialing systems: accreditation and certification. Specialty nurses in New Zealand are able to apply for accreditation through the NZNO Colleges and Sections (for example, in practice nursing, or peri-operative nursing). Advanced clinical practice and leadership is credentialed through a certification process, conferring the title of Nurse Clinician, and stipulating a nominated area of practice (for example, respiratory or cardiac nursing). By 1988, the certification process acknowledged two levels: Nurse Clinician and Nurse Consultant. However, the latter was dropped when the Nursing Council announced in 2001 that it would regulate advanced nursing practice and the nurse practitioner role (NZ Nurses Organisation, 2004).

These discussion documents (NZ Nurses' Association, 1976, 1984, 1987, 1991b) and credentialing processes laid the foundation for the development of a clinical pathway for nurses wishing to stay in clinical practice. Initiated by nurses for clinical nurses in the early 1990s, these programmes were informed by the theoretical work of Patricia Benner and championed by the NZNA since 1976. Although there are regional variations, in general, a nurse wishing to progress on the clinical career pathway submits a portfolio to a peer review panel for assessment and may also be interviewed (Trim, 2001). Clinical career pathway portfolio evidence (generally beyond the level of competence) is a voluntary process applied to the criteria for proficient and expert levels on the pathway or programme. An added advantage of CCPs to the nurse is they encompass the mandatory Nursing Council requirements for competency-based practising certificates.

An important workforce retention strategy, CCPs provided a voluntary career structure for nurses who wished to remain in clinical practice and not divert to either management or education, which were the only options available at the time (Ainge, 1993). Privileging clinical experience, their importance lay in the realisation amongst nurses that while competence was an employer expectation (and Nursing Council expectation), there were possibilities for 'more excellent' nursing practice in the form of expertise. This observation was made by Bronwyn Paterson in 1989, who noticed that hitherto experienced nurses had not recognised the need to move beyond the level of competence. Benner's continuum of ascending levels of proficiency 'novice – advanced beginner – competent – proficient – expert' (Benner, 1984) articulated that possibility.

The following interview excerpt makes reference to a "multiplicity of discursive elements" that together strategise to tactically produce a new representation of nursing (Foucault, 1990, p. 100). These elements are: the recognition of advanced practice; NZNAs role in recognition of advanced practice; competence-based practising certificates; the work of Patricia Benner; professional control of nursing; the visibility of nursing; and skill-mix and remuneration.

> *…within NZNA there was a lot of talk about advanced practice, about things like competence based practising certificates and sort of*

recognition systems for advanced practice, as far back as 1976[38]. And really until Patricia Benner's work came out, I remember the discussions as a member; it was all in the too-difficult basket.

Jill: With nothing to hang …?

Yes, so it wasn't until her work became quite embedded into New Zealand nurses' thinking that things started shifting here. NZNO certification programme for recognising advanced practice, clinical practice, was established in 1988 but there had been a two to three year lead-in time of discussion and policy papers…

And nursing even struggled to keep control of nursing and in part that's why clinical career pathways (which weren't really clinical career pathways – they were differentiated levels of practice recognition programmes) were introduced so that nursing could somehow put in a mechanism whereby they could say this is what is important in nursing and making our nursing visible. These are skill-mix attributes that you need to recognise and want in your organisation and to try and retain some control over our own profession within those DHBs. And I think that reason had as much a part to play in why CCPs were introduced during the 1990s so widely. And why so many of them fell over too was because they were then used to cap and hold down salaries… It was the profession's way of trying to say these roles are important, there are leaders in nursing, we want to recognise people who have the knowledge and skills and attributes of clinical leadership and hopefully that will develop career frameworks in clinical practice (NZNO, p. 4).

The embeddedness of Benner 'into New Zealand nurses thinking' refers to the exposure her work gained through the use of CCPs in workplace settings, but also in various Bachelor of Nursing curricula, particularly following her visit to New Zealand (Price, 1995). Benner's (1984) work *From Novice to Expert* had been used in the United States for career ladder purposes (for example, Nuccio et al., 1996) and presented an opportunity to link levels of competence with

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

remuneration. While the NZNO acknowledged advanced practice in its certification programmes, Benner's framework served to bridge the twin discourses representing nursing and nurses: the professional and industrial.

That nursing was 'struggling to keep control of nursing' was an effect of the political ideology of the neoliberal health reforms, which had replaced clinical nursing leadership with generic management. Retaining nurses became more difficult consequent to an almost flat career structure and cost-conscious working conditions. Representations of the less-visible aspects of professional nursing were made more 'visible' in CCP processes and offered tactical resistance to the managerial domination imposed by the reforms. They were a way to 'try and retain some control over our own profession' by acknowledging the contribution of nursing to patient outcomes and fostering the development of a replacement nursing leadership.

Operating also at this time was a unionist discourse, concerned with 'skill-mix attributes' and salaries. Clinical career pathways identified the experienced nurses in an organisation and by default, the inexperienced nurses, and recommended desirable skill-mix ratios. In terms of subjectivity, CCPs shape a series of ideal modes of being to which nurses must conform. Nurses are defined according to authoritative notions of what it is to be competent, proficient, expert, or otherwise: notions derived from a venerated theorist and academic, but notions that nonetheless divide nurses into levels of practice that differentiate the collective of nursing into individual performance (Mansfield, 2000).

That said, CCPs opened up new career spaces for clinical nurses to move into, interstices that became the precursor to the 'most expert nurse', the nurse practitioner. Like CCPs, this new role was also a retention strategy:

> *…we were facing a major shortage of nurses and retention problems and I've had a long history in workforce planning and workforce development and it was a very obvious solution to that as well. It was sort of a by-product to try and create a clinical career pathway for nurses, keep nurses within nursing rather than leaving and give them something to aim for (NCNZ[1], p. 2).*

As a disciplinary technology, the portfolio required for CCP progression can be likened to Foucault's dossier, which produces docile bodies through systems of a meticulous documentary apparatus (Foucault, 1977a). Where earlier constructions of the nurse relied on direct methods of hierarchical observation and normalising judgment to produce a docile workforce, the dossier relies on indirect and self-imposed surveillance. A less visible form of power, it nonetheless exists in a nursing hierarchy that is no longer continuously present, but where surveillance techniques continue *in absentia* and the dossier is reviewed for the self-disclosed confession of a nurse's practice. No longer docile with respect to working conditions and wages, nurses are now voluntarily positioned against pre-established criteria on a continuum between competent and expert.

For Foucault, the compilation of dossiers makes each individual into a case to be known and brings the minutiae of everyday practice, the most mundane activities and thoughts, into the spotlight for examination (Dreyfus & Rabinow, 1983). Placed in maximum visibility, the nurse's practice can be analysed according to the reigning knowledge about what is and is not accepted practice (Mansfield, 2000). "Thus, with the application of norms, certain behaviour – and thus certain subjects – can be compared with one another, [and] hierarchies of the more or less [expert] can be designed" (p. 62 – 63).

Summary

The original construction of the registered nurse in New Zealand was linked to Victorian ideals of the virtuous woman who under the auspices of medicine, self-sacrificially offered nursing services to those most in need. The disciplinary techniques of the hospital model of apprenticed training served to construct a nursing workforce that was both tractable and productive to the hospital administration and the Department of Health. As a workforce, nursing was eventually unionised, influenced by a social-democratic Labour government and an increased demand for nursing services subsequent to the introduction of the welfare state. No longer considered a *docile* workforce in terms of working conditions, nurses remained *useful* to both medicine and the hospital as it adapted to an increasingly complex medico-technological environment. Discourses of autonomy were beginning to emerge from a developing academic discourse to

produce a registered nurse prepared to engage with notions of extended and even expert practice, no longer content with providing hierarchically organised task-based care.

The shift from nursing as a calling to nursing as a career began with the introduction of a clinical career path for nurses and was a means of nursing gaining control of their expertise. Importantly, CCPs bridged the emerging divide between academic and workforce discourses by officially acknowledging individual expertise in practice and challenging representations of the workforce as homogenous, whilst linking level of competence with remuneration. The potential for a discourse of autonomy to constitute the core nursing identity raises the possibility for not only expertise in nursing, but for the notion of the *most* expert nurse, the nurse practitioner.

Chapter six considers the notion of the competent nurse constructed by discourses of education and regulation. Disciplinary techniques that had shaped the registered nurse continued, but now the tertiary education sector *and* the institution of the hospital worked in conjunction to create the comprehensive registered nurse.

Chapter 6: Constructing the competent nurse

> Half a century ago a young student nurse could enter her name on the register secure in the knowledge that what she had learned was sufficient for half a lifetime. The gathering speed of the technological revolution means that the newly registered nurse must, for the rest of her career, like Alice, keep on pressing her education forward in order to stay in the same place (Salmon, 1982, p. 40)[39].

Introduction

Particular aspects of the history of continuity and discontinuities of alliance within nursing and its constituent discourses of regulation and education have served to construct what I have termed 'the competent nurse' from the 1970s to the 1990s. This chapter is a genealogy of the accidents, the clashes, the absences and the disjunctions that foreground and illustrate how these discourses created 'the competent nurse' and in turn, an interstice for 'the *most* expert nurse', the nurse practitioner.

The notion of 'competence' has long been associated with trained registered nurses. An important function of the Nurses Registration Act, 1901 was that "any one requiring the services of nurses could make sure of getting a competent nurse by reference to this list [the register of trained nurses]" (Mr. Hall-Jones in New Zealand Parliamentary Debates, 1901, p. 387). Once on the register, there was an assumption and expectation of ongoing competence. However, a shift in the use and importance of nursing competence occurred in the 1980s and 90s, influenced by political discourses of neoliberalism and managerialism, and transformed the somewhat loose understanding of competence into a *discourse* of competency.

By a discourse of competency, I refer to a coherent system of discursive practices that construct a nurse as competent to practise. Involved are: *educational* practices of teaching, assessment and examinations; the role of the state in a *regulatory* regime of practices contained in the HPCA Act, 2003 and implemented by the Nursing Council, for example, competencies for entry to the register, submission to state examinations, adherence to the Code of Conduct, restrictions on practice

[39] Original paper prepared for State Services Commission Administration Course No. 76, 17 – 28 November 1969.

and requirements for annual practising certificates (APC) and evidence of on-going competency; other state regulatory practices such as the Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations, 1996, in particular the right of consumers to services of an appropriate standard (Right 4); and *professional* practices related to level of practice programmes in the workplace and the associated activities various levels prescribe. For example, maintaining a portfolio of curriculum vitae, exemplars, case studies, reflection, peer support letters, performance appraisals, professional goals, teaching packages, presentations and evaluations (see Trim, 2001). In addition, there are practices that objectively assess and certificate technical skill (some examples are: immunisation, smear-taking, smoking-cessation, intravenous, central line and epidural certification); and subjective assessments of competence from peers, managers, physicians and patients and their families. Thus the competent nurse is constructed by multiple technologies of surveillance and technologies of the self, which serve to position him/her subjectively in relation to particular discursive practices.

What follows is an examination of the education and regulatory practices that have constructed the competent nurse over the last three or four decades, starting in the 1970s. These practices apply equally, if not more so, to registered nurses working in education and it is these nurses – themselves subject to an academic discourse – who have contributed to the academic discourse shaping the connection between academia and clinical autonomy. The introduction of competency-based annual practising certificates is compared to the experience of Alice mentioned in the opening quote to the chapter, who must press on in order to stay in the same place and the introduction of the Nursing Council's post-registration framework for nursing education.

An academic discourse

The following section foregrounds an academic discourse that served firstly to shape the basic preparation of nurses and secondly, the professional development of existing nurses. Elaine Papps (1997) and Debra Wilson (2001) have conducted detailed examinations of the discourses characterising this period and the construction of a comprehensive nursing identity shaped by multiple discourses

other than nursing. The traditional method of training nurses was in a service-based apprenticeship located in hospitals. In this environment, nurses learned as subjects to the disciplinary power of physicians, matrons and nurses senior to themselves and were expected to behave at all times with virtue and obeisance. Networks of surveillance monitored the routines of nursing and ensured normalisation practices shaped each nurse into the ideal 'type' (Foucault, 1977a). Technological advances in medical care and an increased expectation of the standard of care from the public, as well as changes in society concerning the role of women, contributed to dissatisfaction with the apprenticeship model and changes to the content and location of nursing education were proposed.

Relocating nursing education away from the hospitals and the continuous gaze of physicians and the nursing hierarchy allowed a shift in curriculum content towards discourses that would usefully construct a new nursing identity, the comprehensive registered nurse. An academic discourse proposed by the nursing leadership of the time would position this new ideal of nurse not as a trained nurse but as a nurse educated in the academy and declared to be competent by the academy – a contested declaration by health sector employers and colleagues, many of whom resented the change and expressed concern about nurses becoming 'over-educated' (Shadbolt, 1983). A struggle to establish the authenticity of the new method of nursing preparation ensued, but this academically prepared nurse laid the educational foundation for the later development of an advanced practice role of nurse practitioner.

Shifting the content and location of basic nursing education

The suggestion that nursing preparation should occur in the tertiary education sector arose in the 1960s from a series of reports critical of nursing education in New Zealand (Department of Health, 1986; Reid, 1965a, 1965b[40]; Salmon, 1968; World Health Organisation, 1966). Criticisms concerned the quality of nursing education, high student drop-out and the withdrawal of automatic reciprocal registration for New Zealand nurses in England and Wales (Shadbolt, 1983). There was recognition that the apprenticeship model of nursing education was no

[40] A.E. Reid, an overseas consultant, recommended to the University Grants Committee that the place of nursing education was within the university. At that time, the University Grants Committee negotiated public funding and fund allocation among institutions.

longer serving the needs of hospitals, nor the needs of student nurses (Board of Health, 1974; Department of Health, 1986; NZ Nurses' Association, 1976). The release of the Carpenter Report in 1971 identified the need to shift nursing education away from the fiscally driven apprenticeship model of service delivery to tertiary institutions. With hospital care becoming more complex, it was no longer appropriate to have student nurse employees providing the bulk of nursing care – particularly after hours when supervision was minimal.

There is extensive and most-likely planned commentary recorded in the *New Zealand Nursing Journal,* both prior to the release of the Carpenter Report and for some years after, that endorsed the move of basic education into the tertiary sector (for example, Anderson, 1971; Bazley, 1972; Bohm, 1971; Fieldhouse, 1973; Salmon, 1971). However, the authors of articles advocating the shift represent the views of very senior nurses in the NZNA, the Hospital Matrons' Association, the School of Advanced Nursing Studies (SANS)[41] the Nurses and Midwives Board/ Nursing Council and the Department of Health – all of whom had been exposed to an academic post-registration experience themselves. According to Smith (1998, p. 4), "powerful opposition came from the New Zealand Hospital Boards Association, the Public Service Association and many individuals, including nurses and doctors". Letters to the editor of the *New Zealand Nursing Journal* suggested the profession would be swamped with academic nurses of little practical use ("White Stocking", 1974), who, "isolated from the real involvement in the practical situation can never fulfil her role as a nurse" (B. Smith, 1972, p.7).

Foucault's (1990) rule of tactical polyvalence refers to the effects of domination achieved "according to who is speaking, his position of power, [and] the institutional context in which he happens to be situated" (p. 100). An academic discourse prevailed in this instance as the speakers endorsing the move had the advantage in terms of positions held in each of the institutions that governed nursing decisions. Foucault's rule also avoids the imagination of a simple dichotomy of dominant discourse prevailing over a dominated one, but

[41] Previously known as the Post-graduate School for Nurses, established in 1925.

recognition of multiple discursive elements that came into play to produce a shift from 'learning on the job' towards an academic preparation.

The move to a tertiary education setting to prepare nurses with a Diploma leading to comprehensive registration began experimentally in 1973 in Wellington and Christchurch polytechnics. The new registration replaced the separate preparation of psychiatric and psychopaedic nurses and general and obstetric nurses, incorporating those programmes into the new 'comprehensive' polytechnic diploma (Nurses Act, 1977). Carpenter (1971) had written of the need to educate nurses in communication and behavioural sciences and move to more "broadly-based health-orientated education" (p. 23) rather than illness and hospital-oriented training. A move to a more rigorous academic education thus ostensibly constructed a nurse to be competent to practise in any area of nursing: in medical, surgical, obstetric, psychiatric, or psychopaedic settings, or in the community, by virtue of the knowledge acquired from his/her education rather than on-the-job service. The loss of a distinct psychiatric nursing identity "within the maw of general nursing education" was mourned by John Thompson (1972, p. 5) and concerns about the technical, hands-on knowledge of the new nurses were persistently raised (Department of Health, 1986).

A nationwide trend to close down hospital schools of nursing started – a move recommended to occur over ten to twelve years (Department of Education, 1972) but that was not eventually complete until 1989. Papps and Kilpatrick (2002) raise the issue of the choice of technical institutes by the '1.6 Committee'[42] as the most suitable place for the preparation of registered nurses (Department of Education, 1972) and link it to the influence of Helen Carpenter and her experience in Canada, where nursing education was being transferred to community colleges in the 1970s.

There were two dissenting opinions between the 1.6 Committee members, which resulted in two separate minority reports published as appendices to the main report. The minority report of NZMA member, Dr Wynne-Jones was highly

[42] The committee became known as the 1.6 Committee, named after recommendation number 1.6 of the Carpenter Report.

critical of the technical institute choice, preferring instead the university and felt the nursing members had influenced the whole committee with a predetermined position along with a committee 'stacked' with representatives of the technical institutes. He described the other members' perception of the nurse:

> The main stream of nurse therefore was considered to be incapable of university work thus defining her as being someone who must be trained not educated, a technician not a professional, a non-intellectual rather than a key person occupying a vital role in decision making (Department of Education, 1972, Appendix E, p. 5).

The Hospital Boards Association member, Mr Wicks' report, predictably perhaps in light of the financial losses to be incurred by the loss of a student workforce, recommended an adaptation of existing methods of nursing training and suggested the Department of Education assume responsibility for these schools within the hospitals. He also raised the fact that the principal body with "exclusive jurisdiction" (Department of Education, 1972, Appendix D, p. 6) over the regulation of nursing education, the newly formed Nursing Council, was not represented on the Committee, nor did it make a submission to the committee. French (1998) points out, that on this occasion, "the future of nursing education lay outside the registration authority" (p. 86) and the two traditional disciplinary partners, the Hospital Boards Association and the Medical Association, were unable to exercise control over the final location of nursing education in the technical institutes.

The role of technical institutes, or polytechnics in New Zealand, was to provide vocational qualifications in conjunction with industries and was therefore also linked to the economy (Dougherty, 1999). Natali Allen (1992) suggests there was a general acceptance of the right of hospitals as employers to determine health care needs, reinforcing the industry link and suitability of location of nursing education in polytechnics to meet the future needs of the health care industry. The positioning of nursing education within a vocational context, suggests that despite the recommendations of the 1960s, some discomfort existed about associating nursing with university prepared professions. There was general consensus that the current hospital-based system was not working, so shifting what had been an

apprenticeship model of nursing education to an ongoing association with industry apprenticeships was not an overwhelming ideological shift. Yet the placement of a predominantly female workforce discursively repositioned nursing as a labour force and linked nursing to the service industries, rather than the professions. In spite of an academic discourse driving the changes, dividing practices created a disciplinary space (Foucault, 1977a) for basic nursing education in the technical institutes, but at that time was insufficient to prevent being separated from the professional disciplinary space of the university.

Although the NZNA advocated the closure of hospital schools of nursing (see NZ Nurses' Association, 1984, Recommendation No. 7), an unintended consequence for the Association was control of nurses education shifted from hospital matrons and the Department of Health, to nurse educators in the polytechnics and the Department of Education. The fragmentation of NZNA's alliance with past structures within the Department of Health and now with schools of nursing via hospital matron members, reduced its capacity to maintain a direct and meaningful influence over basic education. Replacing the NZNA were those now officially positioned by an academic discourse in the tertiary education sector and the organisation for Nurse Educators in the Tertiary Sector (NETS), which was established in 1992. The registered nurse, having been constructed by a hospital service-based discourse, could now claim a nursing identity that was linked to the academy to affirm his or her status as a nurse competent to practise.

Shifting the content and location of post-basic nursing education

University education leading to a diploma did exist for registered nurses at the New Zealand School of Advanced Nursing Studies (SANS) in Wellington and administered by the Department of Health. In response to recommendations in the Carpenter Report (1971), degree-level programmes specific to nurses were made available at two universities in New Zealand: Massey University and Victoria University, which in 1973 began offering nursing studies courses within a Bachelor of Arts degree (Board of Health, 1974). Nurses who had already completed a three-year education programme to obtain registration as a nurse, were now exposed to further years of study to obtain a degree (Papps & Kilpatrick, 2002). All the same, a survey of post-basic nursing education

commissioned by the NZNA (NZ Nurses' Association, 1981), reported increasing interest amongst nurses in the extramural bachelor nursing papers offered by Massey University. This was due to the flexibility of extramural study, particularly for married nurses, a high proportion of whom had elderly or infant dependants (King, Fletcher, & Callon, 1982).

The predominant model of ongoing education, however, was usually linked to service, practice-oriented specialty nursing courses undertaken following registration. These courses were referred to as 'post-basic' or 'post-registration' and occurred mostly in hospitals. An exception was the one year full-time Advanced Diploma in Nursing, which was introduced to coincide with the closure of SANS at the end of 1979. Courses were offered at Auckland, Wellington, Christchurch and later Waikato technical institutes and provided a choice of four major clinical specialties (Bazley, 1978). Other post-registration courses followed a similar model to hospital-based nurse training leading to registration, having a significant service component, but lasting six months to a year. The King et al. (1982) survey identified multiple courses provided by hospital boards since, at least, 1948. Shaping nursing practice to conform with a medical discourse, these courses were oriented around medical specialities such as neurosurgery, plastic surgery, cardio-thoracics, operating theatre, intensive care, paediatrics, neonatal and psychiatry and focussed on the technical or hands-on aspects of the specialty. Other advanced diploma and short courses were offered at Polytechnics in management, community health, maternal child health, medical/surgical, psychiatry and in teaching (at Teachers College for nursing tutors). There was keen competition for study leave and a place in a programme.

At the time of the King et al. (1982) survey, undergraduate university study was advocated only for nurses who proposed to enter supervisory positions or above, or nursing tutors. Advanced diploma and hospital courses were considered more suited to staff nurses and charge nurses. That university education was recommended only for exceptional nurses, illustrates how education can serve to reinforce hierarchical nursing structures, distributing individuals in space according to certain long established rules (Sarup, 1996). At the time there was an apparent "lack of conviction among the nursing profession in New Zealand of the

value of university education for nurses" (Papps & Kilpatrick, 2002, p. 10). The presence of obstacles within the workplace with respect to study leave and payment of fees, suggests that nurses who enrolled in university study engaged in resistance to the status quo of service-based learning.

Significant changes to the status of nursing education were brought about through legislative changes to the Education Act, 1989 and the Education Amendment Act, 1990. Respectively, they established the New Zealand Qualifications Authority (NZQA) and allowed polytechnics to confer baccalaureate degrees at level 7 of the NZQA framework. The opportunity for basic nursing education to achieve degree status was seized upon in 1992 by the Auckland Institute of Technology, Wellington Polytechnic and Otago Polytechnic, which became the first institutions to offer a Bachelor of Nursing in New Zealand (Wood & Papps, 2001). Following the international movement towards a degree as entry to practise, by 1999, entry to the Registers of Nursing and Midwifery was by under-graduate degree only and diploma programmes were no longer offered.

Data from a survey of nurses and midwives post-registration qualifications (NZ Nursing Council, 2000) demonstrate extremely high interest in hospital based post-registration programmes and diploma and certificate courses throughout the 1980s and early 1990s. Coinciding with the introduction of a Bachelor of Nursing for entry to practise, the popularity of these courses dropped and the number of registered nurses who completed a bachelor degree increased in the period 1995 – 1999 by 542 percent. The dramatic uptake of RNs undertaking BN study demonstrates an important discursive shift in the construction of a registered nurse ontology. Registered nurses, having been educated towards *competent* technical, hands-on skills, were now exposed to the possibility of *expertise* in clinical practice, informed by the research of Patricia Benner (1984; Benner & Wrubel, 1989). Nursing curricula throughout New Zealand education institutes included Benner's research and found resonance with registered nurses interested in caring and narrative by linking practice to research in a "theory informed by real world experience" (Benner & Wrubel, 1989, p. 5). In tandem with the clinical career pathway development in the health sector, Benner's *Novice to Expert* model

created a space for career progression in clinical practice that had hitherto diverted nurses to either managerial or education roles.

Competent nurse educators

A driver not yet mentioned in the move to pre-service tertiary education for nurses, was the struggle to find and retain qualified nursing tutors. The Carpenter Report (1971) identified only 29.7 percent of tutors had the required SANS diploma and compared nursing tutor qualifications unfavourably with secondary school teachers. These inadequacies were attributed to the reluctance of the Hospital Boards, which were responsible for Schools of Nursing, to invest public monies in the professional development of tutorial staff (B. Smith, 1998). Eventually, the Nursing Council issued requirements pursuant to the Nurses Regulations, 1973 for approval of Schools of Nursing, including the necessary tutor qualifications – and these applied to tutors in post-registration courses also. Nursing Council approval of particular tutors was granted for only one year if the conditions were not met[43] and staff records detailing education and experience, areas of teaching responsibility and workload, as well as records of time spent in clinical with students and on their own account were required for Council inspection (NZ Nursing Council, 1977). Finding the stipulations for tutor training too onerous to implement, many Hospital Boards closed their Schools of Nursing and assented to the move of nurse education to technical institutes (B. Smith, 1998), loosing an inexpensive student labour force in the process.

Nurse educators in the polytechnics and universities were also subject to Nursing Council regulation and were required to "possess qualifications and experience in advance of the qualification being offered" (NZ Nursing Council, 1996/97, p. 10). The institutions offering a diploma required teaching staff to have a bachelor degree and, with the introduction of a pre-service undergraduate degree in 1992, teaching staff were required to have, or be working towards, a master's degree. The Nursing Council survey of educational qualifications (2000) mentioned above, shows a significant increase in nurses or midwives completing a post-

[43] Tutors were required to have completed at least one year post registration clinical experience, hold a basic diploma in nursing or have completed a course in post basic studies, or taken steps towards meeting this requirement within one year of appointment, and have completed a course for teachers, or taken steps toward completion (NZ Nursing Council, 1977).

graduate certificate, diploma or masters degree during the 1990 to 1999 period and follows the tremendous upsurge in registered nurses undertaking bachelor degrees. However, of the 541 nurses or midwives working in education who responded to the Nursing Council survey, only 62 were masters' graduates[44]. Academic upgrade was to have been complete by the year 2000, but these survey figures suggest the time limit was not realistic.

In addition to academic upgrade, following the review of the cultural safety component of nursing education in 1995 (Murchie & Spoonley, 1995), nurse educators teaching cultural safety were required to attend Nursing Council approved courses on the Treaty of Waitangi and on cultural safety. They were to have "a teaching background with adults using facilitation, conflict resolution and group process skills" (NZ Nursing Council, 1996, p. 18). All other staff were required to attend a Council-approved cultural safety course.

Thus in a hierarchy of regulatory surveillance and normalising judgement, the Nursing Council monitors nurse educator competence and they in turn monitor student nurse competence. In Foucauldian terms, the disciplinary institution of the Nursing Council produces a network of regulatory power that transforms and controls nurses towards conformity. By nurse educators taking on the traditional role played by the matron, the same techniques deployed in hospital training are reproduced in the educational institutes and forge docile bodies, which are "subjected, used, transformed and improved" (Foucault, 1977a, p. 136). Normalising judgement punishes non-conformity by failing student nurses, or withdrawing approval of programmes employing inadequately educated staff. That aside, the world of a nurse educator spans both academic and clinical discourses in the teaching of both theoretical and clinical components of the nursing programme. It is nurse educators – themselves subject to an academic discourse – who have led the academic discourse central to the articulation of academia and clinical autonomy.

[44] Figures for post-graduate certificate and post-graduate diploma are not shown by work type in the survey report.

What is more, the impact of neoliberal reforms on tertiary education providers was to introduce a government funding formula based on equivalent full-time student enrollments and created a competitive environment among providers for student numbers (Boston, 1999). The postgraduate education pathway for nurses proposed in the Nursing Council framework documents, generated a market for education providers, relieving much of the pressure placed on nurse educators to attract more revenue for their respective institutions. Foucault's (1990, p. 100) theorising on power and knowledge refers to the "multiplicity of discursive elements that can come into play" and at various times achieve dominance. In this instance, the protagonists in the move towards advanced nursing practice roles were nurse academics. By furthering a discourse of professional nursing autonomy by advocating advanced education, their own futures in education and research were secured.

A regulatory discourse

The role of the state in the construction of the competent nurse is realised in the enactment of particular statutes and corresponding regulations. Both Papps (1997) and French (1998) have comprehensively examined specific legislation that constructs the nursing identity, so it is the intention of this section to focus on the regulatory discourse produced, primarily, through the statutory body of the Nursing Council of New Zealand.

A regulatory discourse refers to a regulatory regime of discursive practices that construct a nurse as competent to practise. These practices are derived from the statutes that make provision for a regulated nursing[45] workforce, specifically the Nurses Act, 1971, Nurses Act, 1977 and its regulations and amendments, (including the Health Occupational Registration Acts Amendment: Amendments to Nurses Act 1977, 1998) and the HPCA Act, 2003. These statutes firstly establish the Nursing Council as a legal and corporate entity and secondly, charge it with the responsibility to safeguard the public. This is achieved through disciplinary practices of surveillance over the educational institutes and staff delegated to provide quality nursing education programmes, the competencies required for registration and the conduct of state examinations. Monitoring

[45] Midwifery regulation is also provided for in these statutes.

principles are then applied to the ongoing competence of post-registration nurses by surveillance of individual nurses throughout his/her career via competence-based annual practising certificates, and the exercise of disciplinary powers against nurses found guilty of professional misconduct (NZ Nursing Council, 2006, July). In turn, the nurse engages in self-monitoring practices, termed by Foucault as 'technologies of the self'. As Rabinow and Rose (2003) point out, these techniques are complementary, but self-management is by far a more effective means of control than external management or domination. In sum, these techniques have the power to control nursing practice and normalise the standard of practice expected of a competent nurse.

Under the Nurses Regulations, 1979, the Nursing Council was able to appoint nurse inspectors (s. 27) to maintain its powers of surveillance of hospital schools of nursing and to have information furnished "on the staff concerned with the education of nursing students … particulars of the clinical experience and educational facilities available and the students" (Notifications to the Nursing Council, s. 21). However, this power of inspection did not extend to technical institutes[46], although the Council was able to request information from an institute (Courses at technical institutes, s. 5) and did so in order to view curricula. A Nursing Council blueprint otherwise guided the curricula in respect to content areas (Nurses Regulations, 1979).

Kinross (1984a, p. 197) refers to a deliberate "move away from central curriculum guidelines devised by the Nursing Council to curricula developed by the faculty of nursing departments". This move reflected the distinction of increased independence afforded the technical institutes, but not Schools of Nursing. The autonomy enjoyed by nurse educators in technical institutes amounted, however, to a loss of direct Nursing Council control of comprehensive programme curricula, although indirect control was possible via the state final examination. In education assessment philosophy this is called 'backwash' (Biggs, 2000) and means that the control of programme content can be achieved by setting the endpoint assessment. In this context, the state examination was set

[46] "Technical institutes" or "Community Colleges" were renamed "polytechnics" (Education Amendment Act, 1990, Seventh schedule: Consequential amendments of regulations).

by the Council and served, to a certain extent, to determine the official curriculum set by an institution. How effective this was as a mechanism is doubtful, as Elaine Papps, Chair of the Nursing Council observed about the inclusion of cultural safety in the state examination:

> I think it was 1991 that the Council resolved to have it included in state final exams, which really didn't do anything… I don't know that people in education really thought about what the implications might be to have this new concept called 'cultural safety' as part of what it had to do in its programmes… (in Wood & Papps, 2001, p. 91-92).

Proposals from nurse educators in 1983 to replace the state examination with internal assessment procedures (Watts et al., 1986) would have removed almost all control of pre-service education from the Council, had the plan proceeded.

In keeping with neoliberal political reforms designed to reduce special-interest group capture and improve accountability to the consumer, the establishment of the NZQA under the Education Act, 1989 shifted the approval and monitoring process for nursing education programmes to the NZQA and exposed nursing education to much wider scrutiny than that available previously (French, 1998). Despite past struggles for control of nursing education between the Council and educational institutes, the NZQA represented a significant threat to the sovereignty of nursing to determine its own future. Nursing Council participation in monitoring panels, as well as representatives from the nursing associations (see New Zealand Qualifications Authority, 2003/2007), became an important means of mitigating outsider control.

Meanwhile, interest in the establishment of professional standards had arisen from a number of authorities outside nursing, such as the Industry Training Organisation, Crown Health Enterprises and Regional Health Authorities. Internal to nursing, special interest groups and clinical career path initiatives were developing nursing standards too (O'Connor, 1995). Encompassing a wider understanding of professional standards to include all the services provided by a hospital, a new organisation, the New Zealand Council on Healthcare Standards, was set up in 1990 for hospitals to voluntarily seek accreditation by comparing the

quality of their services with nationally approved (Australian) standards ("Council formed," 1990).

Ashton (1990, p. 23) mentions two methods of measuring competency: “either examine the product – nursing care in this instance; or examine the practitioner – the individual nurse.” Industry interest in quality and standards measure the end product, but where the regulatory interest of the Nursing Council lay, was in the competence or safety of the individual nurse. Expecting a legislative change in the Nurses Act, 1977 that would remove the requirement for state final examinations, as well as general unease about the Nursing Council’s automatic procurement process for annual practising certificates, as well as following international trends in competency development, the Nursing Council indicated there was a need to develop a set of measurable national competencies or standards for registration (see the Strategic Plan 1994/1997). This was also in line with the Health and Disability Commissioner Act, 1994, which introduced the right of consumers to services of an appropriate standard (s. 20, f). The Nursing Council competencies are, as Papps (1997) points out, a regime of truth, an instrument of power to which nurses become subject. Given the wider political interest in professional standards outside of nursing, it was important, therefore, that nurses in practice engage with the process of competency development (O'Connor, 1995). The Nursing Council consulted widely with the profession on draft consultation documents, but discussion about what constitutes competence appears to have been overtaken by the practicalities of how competence should be assessed (Gallagher, 1997; Oliver, 1999; Trim, 1998).

Over this period, the terms ‘standards’ and ‘competencies’ were used interchangeably, as in the Nursing Council Annual report:

> … initiatives to develop and pilot competencies for safe nursing and midwifery practice, including cultural safety, were completed in 1996. These competencies were incorporated into the 1997 *Standards for Registration of Comprehensive Nurses* and the Standards *for Registration of Midwives* approved by the Council on 13 October 1996 along with the audit tools based on these Standards” (NZ Nursing Council, 1997, p. 5).

One year later, the standards for registration were replaced with competencies, as shown in the Annual Report:

> "…*Competencies for Entry to the Register of Comprehensive Nurses* which replaced the *Standards for Registration of Comprehensive Nurses* and now incorporated with "specific mental health performance criteria" (NZ Nursing Council, 1998b, p. 6).

The significance of this shift in language reflects the need to refer to the requirements for education programmes in terms of 'standards', but the practice of an individual nurse in terms of 'competencies'. Where previously the emphasis of Council was on the adequacy of nursing education programmes and their production of registration-ready nurses, focus was now turning towards the competence of individual nurses on the register. Rather than assume all nurses were competent on the basis of no receipt of complaint, the onus of proof of competence was turning to each nurse to substantiate his/her claim to an annual practising certificate. In this respect, and along with Clinical Career Paths, a new totalising and individualising subjectivity had emerged of articulated competence that established normal levels of competence and increased the visibility of what nurses were doing in their day-to-day practice.

Establishing competencies for entry to the register served a number of important discursive functions: nursing had autonomy over a competency framework; the competencies became the basis for the performance-based annual practising certificate renewal scheme under discussion (Strategic Plan, 1994/1997); and the introduction of competencies justified the regulatory tools of audit and allowed the Nursing Council to regain more control of nursing curricula than could be gained from setting the state examination alone[47]. In fact, the opportunity to audit all the polytechnics with nursing schools arose in 1996 following a Select Committee review of the cultural safety curricula component of nursing education (Wood & Papps, 2001). Given that it was the polytechnics and universities that

[47] The competencies at that time contained eleven specific aspects of nursing practice, a description of the standard expected and up to nine itemised performance criteria for each competency. The competencies were: communication, cultural safety, professional judgement, inter-professional responsibilities, ethical and legal responsibilities, management of patient care and the environment, patient education, quality improvement and professional development.

prepared students for entry to the register and that Nursing Council programme approval occurred only once every five years, the surveillance role of the Council fell only on educational programmes and not individual student nurses (Gallagher, 1998).

Revision of the Nurses Act, 1977 had been anticipated since at least 1994, as indicated in the Nursing Council Strategic Plan by the intention to establish renewal criteria for competence-based annual practising certificates. Additionally, the Ministry of Health had issued a discussion paper on the reform of statutes regulating health sector workers, suggesting the introduction of principles similar to those contained in the Medical Practitioners Act, 1995, particularly those pertaining to continuing competence (Ministry of Health, 1996). The paper proposed the devolution of power from centralised government to registration authorities and was designed to increase the autonomy in professional decision-making by eliminating the detail of registration administration from legislation and Ministerial approval. Essentially a reshuffle of power, the changes would diminish special-interest group capture and improve consumer protection by introducing lay participation in both registration and disciplinary functions.

Six years after the Ministry's discussion paper and following a change of government, the Nurses Act was replaced with omnibus legislation that covered all health practitioners in New Zealand under the HPCA Act, 2003. As expected, the new Act introduced competency-based practising certificates and added surveillance of *registered* nurse ongoing competence to the Council's legal power. The burden of proof of competence shifted to the nurse, whereas previously, the Council must prove a nurse's incompetence to refuse an annual practising certificate. Thus under the Act, the Council can withhold or place restriction on a nurse's APC pending evidence of competence, thereby impacting directly on a nurse's employment (NZ Nursing Council, 2001).

The requirements for an APC are a minimum of 450 hours of practise over three years, a minimum of 60 hours of professional development over three years, a self declaration stating the nurse has met the required standard of competence and payment of the set fee. It is expected that evidence supporting the required

standard of competence will be compiled in a personal professional portfolio for submission to the Council in the event of selection by random audit. Such evidence may be by self-assessment, and/or peer review, and/or senior nurse appraisal, but must "be verified by someone who can attest to the accuracy of the assessment information" (NZ Nursing Council, 2004a, p. 8). In short, a nurse is provided each year with the opportunity to self-examine his or her practice against the competencies and sign a legal document (the APC application form) to that effect.

Where previously the regulatory role of the Nursing Council concerned education programmes that led to entry to the register, the state nursing examinations and disciplinary proceedings, the ongoing competence of registered nurses was added to the Council's surveillance portfolio. Where once, under the Nurses Registration Act, 1901, information entered on the register about a nurse was her name, address and hospital at which she trained, in 2006 under the increased administrative requirements of the HPCA Act, 2003, a dossier on each nurse is held by the Council containing "all communication of initial registration, practising certificate applications, audit round, verifications, applications for change of scope … and conditions and all miscellaneous correspondence" (NZ Nursing Council, 2006, July, p. 2).

Foucault (1977a) problematises dossiers as a documentary apparatus of surveillance, a point already raised in chapter five in relation to the portfolio compiled by a nurse for progression on a clinical career path. The effect of the dossier with regard to the Nursing Council, however, is "a certain crossing of power and knowledge" (Dreyfus & Rabinow, 1983, p. 160) where disciplinary techniques of surveillance combine with the developing science of (most probably) workforce planning. Such planning can lead to highly desirable and productive outcomes and as Foucault (1983a) points out, is not necessarily bad – although it is dangerous. Making claims to 'truth', the effect of the dossier is one of power, always at work to encourage its acceptance as necessary and inevitable, all the while containing knowledge that classifies, categorises and constructs particular subjectivities that may or may not be occupied (Mansfield, 2000). And so, the dossier can pronounce a nurse as competent because there is no evidence

to the contrary; or not competent because of substantiated evidence; or possibly not competent on the basis of a poorly articulated portfolio. As Mansfield suggests, these documentary constructions should be regarded with skepticism as they may or may not reflect the 'truth' about a nurse at all.

The Council's new form of power can be described as "continuous, disciplinary, and anonymous" (Dreyfus & Rabinow, 1983, p. 189). The nurse continually collects evidence that his or her practice compares favourably to the normalising judgment of the competencies; and, the nurse is selected for audit by anonymous randomisation techniques and then audited by a Council staff member, who will likely remain anonymous to the nurse, unless more information is required. As a disciplinary technique of meticulous ritual, APCs subject a nurse to an application of hierarchical observation and normalising judgment in the optics of Nursing Council surveillance (Foucault, 1977a).

Ongoing competence: The Red Queen hypothesis

The quote from Bea Salmon at the beginning of this chapter refers to the passage in Lewis Carroll's story of 1872 '*Through the Looking Glass.*' Alice and the Red Queen are running as fast as they can, when Alice notices that as fast as they run, nothing seemed to change. When questioned, the Red Queen replied, "Now, *here*, you see, it takes all the running *you* can do, to keep in the same place" (p. 109). In evolutionary biology, this principle is called the 'Red Queen hypothesis' and refers to the necessity for species to keep evolving (moving) in response to challenges, or risk extinction (Ridley, 1993). So it is for the registered nurse who must now, under the HPCA Act, 2003, continue to meet the competencies for entry to the register in order to retain an annual practising certificate. Due to the pace of evolving nursing and medico-technological knowledge, a nurse has to 'run' to stay abreast of these changes.

Professional development as a requirement for an APC acknowledges the fast pace of change in knowledge development. From 1999, pre-service education prepared nurses for entry to the register at degree level and made it necessary to establish the status of courses undertaken by registered nurses thereafter. A joint position statement, published by NETS and Nurse Executives of New Zealand

(NENZ), clarified categories for the plethora of education programmes available to nurses and distinguished between "those that prepare for or maintain workplace competence" and "those that contribute toward a post graduate degree" (Nurse Educators in the Tertiary Sector, 1997, p. 4). In keeping with the 1994 Strategic Plan of "implementing post-registration standards and competencies" (p. 15), the Nursing Council began to consult on developing a formal framework that incorporated both education and competencies for specialist and advanced nursing practice.

The consultative process for a post-registration education framework began in 1996 and produced three draft documents. The final document was released during the work of the Ministerial Taskforce on Nursing in May 1998 (discussed in chapter seven). The framework proposed "a pathway from beginning nursing practice through to advanced nursing practice for those nurses wishing to pursue post-registration nursing education at other than the continuing education level" (NZ Nursing Council, 1998a, p. 8). The Minister of Health then requested that the Council establish competencies and monitor programmes for nurse prescribing in child family health and aged care, and these were added to the advanced nursing practice competencies in the 1999 framework for post-registration nursing education document (NZ Nursing Council, 1999).

The following text is an excerpt from an interview with a Nursing Council member, who recalls the interest displayed by nurses during the consultation process:

> *But it was interesting in taking out the advanced nursing education framework, we took that up and down the country and we got huge attendance. Lots of debate and reasonably good acceptance. I mean, it was built on a pretty safe premise that if everyone is in a degree programme now, then the next level would have to be a masters. The old die-hards would fight you to the death on it, but the new young ones coming up wouldn't. And I always thought that was an interesting thing with Nursing Council too, because we put the new grads on the register, I reckoned there was a responsibility to have some direction in place for them (NCNZ [3], p. 8).*

The speaker refers to two kinds of nurses: the 'die-hards' and the 'new young ones' and in broad terms, pertains to those nurses with a degree and those without. As it was in the 1970s, when nursing education was relocated to the education sector, there is inevitable resistance from nurses who registered with a certificate or diploma and are now confronted by master's level study for which they are not academically prepared. However, a false dichotomy is constructed by the either/or categorisation of nurses attitudes to graduate and post-graduate education, suggesting nurses can belong in only one of two categories, when in fact, nurses attitudes are likely to vary considerably. The language further divides nurses into young and old categories, suggesting older nurses are particularly resistant to change, when in truth, many older nurses embraced masters and doctorate level education (see NZ Nursing Council, 2000). Positioning the introduction of post-graduate education in war-like terms ('the old die-hards would fight you to the death on it'), is, as Foucault identifies, to do battle, to have adversaries, to fight for a victory. Specifically:

> he tries to make right prevail, but the right in question is his particular right, marked by a relation of conquest, domination … and if he also speaks of truth, it is that perspectival and strategic truth that enables him to win the victory (Foucault, 1997b, p. 61).

The assertion by the speaker of a new strategic truth (or reality) of post-graduate education initiates "a discourse in which truth functions as a weapon for a partisan victory" (Foucault, 1997b, p. 63). A more productive position may have been to adopt an attitude of reconciliation between the apparent divisions of die-hards and young ones.

Recognition of a new graduate's entry to the register as a beginning point – and not an end – reflected the academic discourse that increasingly characterised nursing discourse in the late 1990s. Furthermore, the NETS (1997) position statement, which represented both nursing education and nursing practice (Jacobs, 1998), specifically articulated a connection between academia and clinical autonomy: "Entry into practice is currently through an undergraduate programme, with programmes thereafter either preparing the nurse for advanced practice or

developing other professional knowledge which advances the discipline and autonomy of practice" (Nurse Educators in the Tertiary Sector, 1997, p. 1).

Thus the shift of nursing education to a nursing degree and the anticipation of legislation that would enable the Council to implement competency-based APCs, led to a framework of education that revolved around studies that went beyond a bachelor's degree to post-*graduate* study. Hospital or service-based continuing education and short courses would 'count' as professional development for the purposes of an APC, but the framework provided a pathway that dovetailed with a gathering impetus for an advanced nursing practice role and included nurse prescribing (see chapter seven).

Summary

This chapter has brought to the foreground the discourses that construct the registered nurse as competent to practise. Over the last decade or so, educational and regulatory practices, shaped by legislation, have played a principle role in creating a new subjectivity for nurses, one of assured competence. An academic discourse dominated the move from an apprentice model of nursing education to a pre-service diploma, followed by a degree as entry to the register. Accordingly, a nurse was declared to be competent by the authority of the academy. Based on the research of Patricia Benner, the possibility of expertise in clinical practice created a space for exploration of advanced practice roles and competencies, in tandem with the Nursing Council's post-registration education framework (1998a, 1999).

The neoliberal political climate of the 1990s embraced an agenda of increased consumer choice, balanced against increased consumer protection, through increased practitioner accountability. It found expression in legislation such as the Health and Disability Commissioner Act, 1994 and its associated Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations, 1996. As the principle driver of legislative change, political ideology neatly dovetailed with the Nursing Council mandate of protecting public safety. The anticipated revision of the Nurses Act, 1977 allowed forward planning for the eventual implementation of competency-based practising certificates, including a framework for education that went beyond a bachelor's degree to post-graduate

study. The Nursing Council gained a new form of power under the HPCA Act, 2003 to monitor the competence of registered nurses via the application process for an annual practising certificate. Accordingly, a nurse was declared to be competent not only by the academy, but by the Nursing Council, by self-declaration, by nursing peers or managers and by the evidence contained in the dossier.

Following graduation, the new ideal type of nurse would maintain competence by regularly engaging in professional development activities and reflecting on the ways his or her practice meets the Nursing Council norm of competent practice. The Red Queen hypothesis suggests these are necessary behaviours for a nurse who intends to stay "in the same place", but should he or she "want to get somewhere else", running "*twice* as fast as that" becomes necessary (Carroll, 1872, p. 109). That is, for the nurse to meet specialist or advanced competencies, his or her practice must be supported by post-graduate education leading to a master's degree. Thus the specialist or advanced nurse can be differentiated from the ordinary competent nurse, which comprises the bulk of the nursing workforce.

Finally, the Nursing Council is now concerned with the surveillance of a nurse from entry to the register as a beginning point – and not an end – and reflects a significant shift in the extent of the Council's regulatory power. The approval of post-graduate programmes and advanced nursing competencies fell to the Nursing Council to regulate and became the focus of a struggle within nursing for power to control the pathway to an advanced nursing role, the *most* expert nurse, the nurse practitioner. This struggle is examined in the following chapter.

Chapter 7: Constructing the Most Expert nurse

Introduction

This chapter examines the struggle within nursing for power to control its future. Discourses of neoliberalism, academia, regulation, autonomy and unionism converged with the establishment of the Ministerial Taskforce on Nursing in February 1998, to challenge past constructions of nursing and its contribution to health services in New Zealand. Assumptions concerning the mandated location of regulatory practices for advanced nursing practice revolved around two dominant discourses: autonomy and unionism. As a consequence, the nurse practitioner role became the locus for the enactment of an internal power struggle within nursing.

The discourse of autonomy woven throughout the thesis is developed in this chapter to consider a new phase in nursing autonomy, not only related to clinical autonomy, but to professional self-determination. Historically, medicine has been involved as of right, at every turn, but by and large, medicine remained outside of this development, until such time as prescribing rights for nurses were proposed. Contestation of prescribing and the traditional jurisdictions of medicine are examined in part three of the thesis. In contrast to the 1974 report *An Improved System of Nursing Services in New Zealand,* the *Report of the Ministerial Taskforce of Nursing* (1998) was entirely nurse led, without medical representation in the Taskforce membership, but with only one NZNO representative. The 1974 report considered 'extended' nursing roles, whereas the Taskforce proposed 'expanded' nursing roles and encompassed a wider and more impressive horizon than previously defined by the notion of extended. A hallmark of an expanded nursing role is its independence from medicine; although not preclusive of collaboration, it circumvents the *requirement* for medical collaboration.

Autonomy as a discourse articulates closely with an academic discourse and its constituent educational practices, situated at post-graduate level. Teaching and assessment remain as fundamental practices, but the educational emphasis is on

the individual's development of critical analysis and synthesis of practice, research and leadership, to construct an autonomous practitioner who is *most* expert in his or her particular scope of practice. The combination of research, advanced education, practice experience and ability (A. Adams et al., 1997; Paterson, 1987), marks a professionally self-determined and expanded scope of nursing.

The discourse of labour threaded through the various representations of nurses discussed in chapter six, developed into a coherent system of discursive practices associated with the Trade Union movement. As such, nurses are represented not only as a workforce, but also as members of a democratic organisation with collective worker rights. Elected union officials work as servants to the members, whose will is sovereign (Deeks, Parker, & Ryan, 1994). The power/knowledge regime of unionism is both enabling and constraining, being constituted by values of egalitarianism, solidarity, justice, fairness, democratic participation and consultation. Importantly, nurses are constituted under the normalising influence of the collective, to which the interests of the individual are subordinate. In Foucauldian terms, individuals exhibiting abnormality are subject to dividing practices of exclusion (Foucault, 1977a). The 'rank and file' of union membership, reminiscent of enlisted troops in marching formation, depicts conformity as a central value of unionism. In this depiction, there is ironic remanence to the army origins of nursing. Indeed, having its roots in revolutionary Marxism, unions are associated with battle metaphors of victory, defeat and militant strike action (Deeks et al., 1994). The worker, viewed by the capitalist as a commodity, must strive for progressive control of production processes. In the context of nursing, the members themselves must control the commodity that is their labour, by processes of professional self-determination.

Thus the route to professional self-determination differs as each discourse positions nurses and nursing in subjectivities that conflict: autonomy privileges the individual and his or her attainments and specific contributions to health-care needs; unionism privileges the collective strength of its membership and improved health services via a non-exploitative work environment that furthers professional development for all nurses. The following chapter traces the clashes engendered

by these discourses on the constitution of the Ministerial Taskforce on Nursing and the international influence on its work and recommendations. The withdrawal of the NZNO from the Taskforce following the second draft of the report highlighted the divisions present within nursing. Eventually, a consensus position was reached, making space for the consequent construction of the *most* expert nurse, the nurse practitioner.

International influences

Susan Jacobs (1999) asks why a focus on advanced nursing practice had occurred over the preceding eighteen months to the commencement of the Taskforce. She describes a gathering momentum of discussion towards advanced nursing practice that maintained a distinctive clinical focus. A number of factors converged to give the discussions impetus (and these are discussed in detail by Jacobs, 1998): in 1995, as part of the health reforms, the funding for post-entry clinical training of the health workforce was unbundled from hospital budgets and the Clinical Training Agency (CTA) was established, making an additional $5 million available in early 1998 to purchase clinically focused post-registration nursing education; the Nursing Council framework document for post registration nursing competencies and education began circulation in 1996; a position paper modeled on the US advanced practice roles of clinical nurse specialist and nurse practitioner was developed by Nurse Executives of New Zealand during 1995-96; a position paper by Nurse Educators in the Tertiary Sector in 1997 about post registration nursing education was written; the Ministerial Taskforce on Nursing, from February to July 1998, took place; there was an announcement, by the then Minister of Health, that an amendment to the Medicines Act 1981 would enable nurse prescribing; a Nursing Council decision was made in early 1998 that entry to the register was by bachelor degree only; and an advanced nursing practice workshop was hosted by the College of Nurses Aotearoa, in March 1999.

These events and documents did not occur in isolation, but were informed by the international experience of nurse practitioners and the published literature concerning their efficacy. The research evidence the Ministerial Taskforce on Nursing cited in its report, foregrounds the academic discourse drawn on to

support the introduction of a nurse practitioner role for New Zealand[48] (Bissinger et al., 1997; S. Brown & Grimes, 1995; Fall et al., 1997; M. E. Jones & Clark, 1997; D. J. Mason, Cohen, O'Donnell, Baxter, & Chase, 1997; Shiell et al., 1993). Each of these studies provides evidence of the efficacy of nurse practitioner practice across a variety of settings. However, the constant comparison of nurse practitioner practice to medical practice positions nursing always in relation to medicine, demonstrating nurse practitioners provide often better and cheaper care, but mostly equivalent care to physicians.

Subsequent published international evidence is supportive of the contribution of nurse practitioners to health outcomes and has carried significant weight with politicians and physicians in New Zealand, particularly as the debate over nurse prescribing intensified. In Foucauldian terms, the high value placed on research evidence, illustrates the power of a scientific discourse to produce a 'regime of truth'. Research "techniques and procedures are accorded value in the acquisition of truth" and makes it possible "to distinguish true and false statements" (Foucault, 1991a, p. 73). Ultimately the nexus between technology and power produces what counts as true and, in this case, articulated with the academic discourse of particular nurses to further their argument for an advanced nursing practice role.

Ministerial Taskforce on Nursing

Kathryn Adams (2003, p. 303) reports towards the end of 1997, Jenny Carryer Executive Director of the College of Nurses, "approached the then Minister of Health, with a proposal that a high level strategy was needed to resolve the complex matrix of barriers impeding the full utilisation of nursing services". As a result, the Ministerial Taskforce on Nursing was commissioned in February 1998 by the Minister, in response to the "obstacles to the nursing profession realising its full potential" (Ministerial Taskforce on Nursing, 1998, p. 3). A report was due at the end of May, but an extension of one month was granted to allow for wider consultation ("Nursing taskforce granted a month's extension," 1998). It was

[48] The NENZ document is not referenced, and the Nursing Council documents on post-registration nursing education reference mostly to its own policy documents, the Ministerial Taskforce on Nursing, the Ministry of Education, and the NZQA, and not to research specifically.

followed by another extension until the end of July, 1998 (Oliver, 1998). The tight timeframe was agreed to because of the likelihood of the Minister of Health changing to the finance portfolio before the Taskforce recommendations had been considered.

The precedent of restored professional autonomy to midwives, under the Nurses Amendment Act, 1990, ostensibly offered similar possibilities for nursing. Reflecting on midwifery and other health sector changes, a senior politician involved in the health portfolio and interviewed for the study, acknowledged the influence changes to maternity services had on the decision to proceed with a ministerial review:

> *I was influenced then by my own positive view about changes for midwives and maternity services … I could see the potential for nursing to go down the same path, but it was reassuring that the nurses seemed more pragmatic. The hurdles were fairly formidable for a nurse to get to the position to be able to do anything that would be even remotely threatening to GPs was a long way. It was a lot more challenging than just a change in funding for one service, as in the case of midwives.*
>
> *But nurses work in a more complex environment. It wasn't just a matter of one change to one service. I thought then the variety of things that nurses do is much wider and you may be able to expand practice quite significantly in some areas but it would be very difficult in other areas. So a process of change for nurses would be less reliant on political sponsorship than the midwives and more about solving practical problems to do with services and skills one by one. It could never move too far too fast and I understand it hasn't. That's why I felt changes in nursing practice were much less of a threat to doctors than changes in midwife practice.*
>
> Jill: So those ideas must have been going around in your head when the proposal for a review came up.
>
> *Well the idea of a review didn't seem to me to be that big a deal at the time quite frankly; in retrospect it was. There were some pretty articulate advocates. You have to remember the context at the time. There was some*

> *big pressures for changes in service delivery, so every second hospital was going through its business process, clinical pathways, there was a huge pricing exercise going on with all sorts of stuff about how services were organised, quite significant restructuring in the primary sector, the IPAs getting up and going underpinning it. In any case, there were gaps in primary care nurses could potentially fill, more opportunities than the practice nurse. We had pushed the Health Commissioner[49] legislation and the Medical Practitioners Act[50] through, so there was a lot going on. In the context of all this change, it seemed logical to look at what the largest professional workforce could do (Senior Politician[2], p. 3 - 6[51]).*

Changes to maternity services increased the autonomy of midwifery, but were ideologically driven by the neoliberal view of increased consumer choice, which drove the market for particular services. The legislation the above study participant made reference to, intentionally brought a consumer focus to the health services, requiring practitioner accountability for the provision of competent care. Recipients of health care now had rights under the Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations, 1996 and as 'consumers', could legally exercise those rights with impunity. Expanding the range of services potentially offered by nurses simply expanded the range of consumer choice, but would do so in a less contentious way than the changes to midwifery had done. That is, nurses seemed less idealistic ('more pragmatic') than midwives and, because of the diversity of nursing practice, were less likely to ever be a credible challenge to medicine because of the 'fairly formidable hurdles' in the way. This politician did not, therefore, anticipate the significance of the Taskforce findings.

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[49] The Health and Disability Commissioner Act, 1994 – the purpose of which is "to promote and protect the rights of health consumers and disability services consumers, and, in particular, to secure the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights" (s.6).

[50] The Medical Practitioners Act, 1995 introduced measures requiring the Medical Council of New Zealand to ensure the continuing competence of medical practitioners. The major concepts from this Act were carried forward into the HPCA Act, 2003.

[51] This interview excerpt is collated from three pages of the transcript. Digressions from the topic have been omitted. Some words have been altered to protect anonymity but the order of ideas has been preserved. Caelli (2001) supports this technique, suggesting "deriving the story from the interview transcripts is indeed an accepted way of proceeding" (p. 278).

Tapping in to a neoliberal discourse was a deliberate strategy of nursing leaders, who wanted greater opportunities for nurses to use their autonomy in ways that would benefit the public.

> *But that's how the political process works, is that smart operators piggy-back on current trends. So that's what we did was to piggy-back on the drive for economic reform by suggesting a new kind of worker. None of us ever had in our heads that nurse practitioners would simply be a cheaper way of doing the same thing (the College, p. 9).*

The speaker in this text suggests that cooperation with a political ideology of reform could further the interests of nursing, in ways that resistance to it had not. This is not to suggest that 'a new kind of worker' would be a 'cheaper' worker, but one that would offer greater choice of health care provider to consumers. At the same time, it would advance a nursing agenda by creating an interstice for an expanded nursing role.

Taskforce membership

The Minister appointed a nine-member team comprised of a representative from each of the major nursing groups: the College of Nurses, NZNO, NENZ, NETS and the Nursing Council. Nursing members were Jenny Carryer, Executive Director of the College of Nurses; Brenda Wilson, Chief Executive of the NZNO;[52] Frances Hughes, Chief Nursing Advisor for the Ministry of Health; Judy Kilpatrick, Nursing Council chairperson and Head of School at the Auckland Institute of Technology, as well as being a member of NETS[53]; Julie Martin, Manager of Nursing Services at the Health Funding Authority; Denise Wilson, Nurse Consultant at Lakeland Health; and Beth Cooper-Liversedge, Clinical Director of Nursing at Good Health Whanganui and member of NENZ. Non-nursing members were Toni Ashton, Health Economist at the University of Auckland; and the Hon Dame Ann Hercus who was appointed chairperson. Members were selected for their particular skills and attributes, but a 'fair' and

[52] In 1993 the NZNA, representing nurses in the public sector merged with the private sector nurses union, the New Zealand Nurses Union (NZNU). The new organisation was called the New Zealand Nurses Organisation (D. Wilson, 2001).
[53] Judy Kilpatrick was appointed to the Nursing Council as a NZNO nominee in May 1996 (Wood & Papps, 2001).

united representation was an overriding goal. Commenting on the Taskforce constitution, a study participant recalls the tension between the NZNO and the College at the time:

> *There was a sort of an agreement from the main organisations to try and get someone from every main organisation on the Taskforce, so that we could present a united front. Because as you know our history was, if we can shoot each other publicly, lets do so. So there was a very genuine attempt to have a united voice.*
>
> Jill: Do you think the NZNO felt that way?
>
> *They certainly didn't at the end. And I'm not sure they even did at the beginning. I think they came on reluctantly. It was in a period of absolute mistrust. NZNO didn't like the College; they didn't like the College of Midwives. Those organisations didn't like NZNO. It was an abrasive organisation. Things were confrontational (NCNZ[3], p. 7).*

The Taskforce genesis was not, however, bipartisan, in the sense that the approach to the Minister originated directly from the College of Nurses without reference to the NZNO. Its unilateral inception secured transcendence and a dominant voice in the Taskforce membership for the College, despite the appearance of being representative of the major organisations. Representatives from organisations other than the NZNO were also College advocates and members as senior nurses and academics (Carryer, Denise Wilson, Martin, Cooper-Liversedge, Hughes and Kilpatrick) and gave the College a clear majority voice on the Taskforce. The College membership was perhaps 800 at the time, compared to a declared membership of the NZNO of 26,000 (O'Connor, 1998), but secured only one member on the Taskforce team. As the country's largest professional organisation, the NZNO anticipated having a greater sway than other Taskforce members and stated that "No other taskforce representative can claim that [membership] mandate" (B. Wilson, 1998, p. 2). Furthermore, the NZNOs historical position as sole nominator to government and nursing advisory committees was severely compromised; a threat that re-emerged during the work of the Taskforce under the Health Occupational Registration Acts Amendment (HORAA) 1998, discussed later in this chapter. The 'deliberate arrangement' (or stacking) of members without active union affiliation, played a role in tactically blocking the unionist

discourse of the NZNO. The appointment of members by the Minister could be interpreted as a deliberate strategy to subdue industrialism, which is inherently antithetical to neoliberal politics.

The hasty assemblage of Taskforce membership also jeopardised effective consultation with Māori, ironically the group most disadvantaged by the current health service (Hefford, Crampton, & Foley, 2005) and most likely to benefit from a more accessible nursing workforce. There was no acknowledgement of the Treaty of Waitangi in the Taskforce terms of reference and the attendant requirements for participation and partnership with Māori (Ministerial Taskforce on Nursing, 1998). However, the Taskforce members considered themselves "bound by the Treaty relationship" (p. 11) and as such, endeavoured to traverse both Māori and non-Māori worlds to negotiate a consultative process that would meet the needs of both. The difficulties encountered are outlined in the preface to the Taskforce chapter on Māori issues and revolve around the inadequate consultation process over selection of the Māori representative from the outset. The Taskforce member to whom leadership on issues for Māori fell, then had the unenviable task of representing Māori interests without a clear mandate from Māori. As a consequence, she attended five of the six hui[54] held throughout the country, without kaumatua[55] support. The lack of support and recognition of Māori processes were documented in the report:

> Concern was also expressed that Māori representatives were often alone … Often kaumatua and kuia are not part of the representation, yet are essential for the support and safety of representatives when walking amongst Māori … This is interpreted as a seemingly total neglect of the partnership between non-Māori and Māori … Consultation was seen to be undertaken within a non-Māori framework; this raised concern that, despite the bicultural nature of Te Tiriti o Waitangi, a lack of recognition existed in relation to the differing timelines and processes (Ministerial Taskforce on Nursing, 1998, p. 82).

[54] A gathering of Maori, often on a Marae
[55] Wise, experienced members of the whanau.

Privileging a non-Māori frame of reference in terms of timelines and processes, in the interests of expediency, meant Māori tikanga[56] was neglected and the pervasive disregard for cultural practices intrinsic to the health sector was paradoxically reproduced. Consequently, "the use of processes that are acceptable and appropriate to Māori for representation and consultation [and] are vital for the achievement of positive health outcomes" (Ministerial Taskforce on Nursing, 1998, p. 82), were subsumed in the more powerful Ministerial process.

Work of the Taskforce

The Taskforce were charged with the task of recommending "strategies to remove barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders" (Ministerial Taskforce on Nursing, 1998, p. 8). Issues to do with midwifery practice and enrolled nurses were considered outside of this brief, as were issues to do with nurses' pay and working conditions. The recommendations of the Taskforce concerned access to funding, education, research, management and leadership, workforce resourcing, issues for Māori and expanding the scope of nursing by developing new nursing roles. This last concern (addressed first in the report), is the focus of the next section because it identified a nurse practitioner role for New Zealand in conjunction with particular tasks traditionally aligned with medicine; those of prescribing medication, ordering diagnostic and laboratory tests and specialist referrals. The Taskforce were clearly influenced by the US experience of nurse practitioners, referring to overseas literature and also the April publication by NENZ[57] (1998), in which the roles of clinical nurse specialist and nurse practitioner for New Zealand were discussed. The NENZ document positions nurse practitioner education at masters' level.

At the time, nurses around the country were being appointed to senior clinical positions with titles such as nurse consultant, nurse practitioner, independent nurse practitioner, neonatal nurse practitioner, clinical nurse specialist and clinical nurse advisor. These titles lacked national consistency and links to levels of

[56]Māori word for protocol
[57]Taskforce member Beth Cooper-Liversedge as a member of NENZ helped to develop this document.

education and competence. However, during the work of the Taskforce, the Minister announced an Amendment to the Medicines Act that would provide for limited nurse prescribing. Legislation that would enable nurse prescribing then became a catalyst to defining a consistent advanced role that was not industry driven, but professionally determined:

> *I don't think that we would have the nurse practitioner title in this country yet if we hadn't started with prescribing. That was a very deliberate strategy from a few of us … it was a catalyst to defining the role. Because if we hadn't had legislation pending about that we would never have had to designate it to a title. We would have kept a proliferation of undifferentiated titles at employee level rather than at a professionally-owned level (Nurse academic, p. 4).*

Linking prescribing to an advanced practice role is described here as 'a very deliberate strategy'. Work on nurse prescribing had been ongoing since at least 1992, and the publication of a public discussion paper written by John Shaw in 1994. The international research about nurse practitioners, referred to in the Taskforce report, describes settings where nurses prescribe and practice with autonomy. The timing of the announcement (International Nurses Day, May 12), rather than the Amendment itself was a surprise, being in many ways a political gesture to give the report credibility, when it otherwise risked being just another report:

> Jill: Because that was another thing – the Amendment to the Medicines Act – during the work of the Taskforce.
>
> *Yes, that was controversial.*
>
> Jill: Mmmm.
>
> *I remember thinking that was probably controversial.*
>
> Jill: Well the timing was interesting. It really shaped up what the Taskforce ended up producing.
>
> *The risk with a review is that the report is nice but it's just a report and it's too hard to actually change anything as a result of it. The amendment to the Medicines Act gave the review and the thinking behind it some credibility; a political signal that changes could and would happen (Senior Politician[2], p. 7).*

The announcement was controversial, not only because of the challenge to traditional medical jurisdiction, but also because of the level of education necessary for nurses to become competent prescribers. Positioning prescribing within an advanced practice role that was located within a clinical masterate, served as a dividing practice to separate the 'elite' masters-prepared nurses from the majority of nurses. This was problematic for the NZNO, who on the one hand, were seeking to acknowledge advanced nursing practice, but on the other, were bound to an egalitarian ethos inconsistent with status differences. That said, the NZNO welcomed the Minister's announcement, although they had envisaged prescribing papers to be "incorporated into a Bachelor's degree" (Manchester, 1998, p. 12), the precedent being midwives who are prepared for prescribing in a Bachelor of Midwifery. Nurses as prescribers *per se,* however, were not the issue; the core issue was the level of education required. It was also controversial to physicians, who are, after all, only prepared as prescribers to bachelor level.

It has also been argued that the fit of the nurse practitioner role with a government programme of cost reduction and simultaneous improvement in both quality and access to health care, suggests government support for an advanced nursing role may have arisen more from an economic imperative, than a desire to advance the nursing profession. Reduction in specific interest group capture by the liberalisation of legislative controls over prescribing and registration authority membership, did articulate with a nursing agenda of autonomy and an expanded role for nursing. However, this in turn can be read as the ability of nursing roles to be a manipulated commodity, used to manage skill shortages, while at the same time, meeting market needs and controlling cost (Beekman & Patterson, 2003).

Points of contestation: The power and authority to write nursing

The following section foregrounds the clashes between discourses concerning the location of regulation for advanced nursing practice. A power struggle, characterised by two discourses – autonomy and unionism – revolved around control of the future development of nursing. Two nursing associations, polarised by differences in values and beliefs, represented these discourses and frame the following discussion:

> *…right at the outset when the College was established in 1992 it suited the dominant discourse in nursing to construct the College as the elitist, academic, loopy, fringe of nursing and NZNO as the good, honest coalface workers (the College, p. 4).*

Already in existence were credentialing mechanisms within NZNO to recognise specialist and advanced nursing roles (see chapter five). Nurses submit written evidence demonstrating stipulated criteria, which is reviewed by a board of nominated peers (NZNO, 2003). Within this framework, the need for master's level education for advanced and specialist roles seemed unnecessary, because the profession already had a process to acknowledge those with extensive clinical experience. Furthermore, the costs of masters-level education were seen as prohibitive for many nurses (B. Wilson, 1998; NZ Nurses Organisation, 1998, July 30) and ran "the risk of becoming elitist because of cost" (O'Connor, 1996, p. 29).

With the credentialing system in place, the NZNO were seemingly well positioned to take on responsibility for professionally recognising an advanced nursing role. This was a crucial issue for the NZNO and was one of the key reasons it withdrew from the Taskforce (discussed below). A flyer outlining those reasons stated that "NZNO believes the profession must set its own standards in an inclusive and professional manner. NZNO's sections and colleges are an appropriate national structure for recognising and developing advanced practice" (NZ Nurses Organisation, 1998, July 30). Aside from the presupposition of the existence of only one nursing organisation (Jacobs, 2000), restriction of trade practices played a role in preventing the NZNO from being seriously considered as a potential accrediting body:

> *So what does credentialing mean? It means nothing unless it's linked entirely to the regulatory body. The Colleges of Medicine link back to the Medical Council. They [NZNO] were credentialing in a vacuum, they weren't credentialing with the endorsement of the Nursing Council. And also, we needed to be careful that we weren't doing it to restrict trade practices, which I think they were.*
>
> Jill: Restrict trade practices?

Hiring only people who were credentialed could do it, plus if NZNO did it, only NZNO members could do it (MOH, p. 1).

The speaker in this text stresses the importance of linking credentialing mechanisms to the regulatory body, comparing the process to occupational licensing for medicine[58]. The risk of a union performing credentialing functions is that a 'closed shop' situation could arise, where employees are required to be credentialed union members, as a precondition to employment.

Protecting the future interests and survival of the College, the Taskforce recommended the New Zealand Nursing Council develop, control and enforce competencies for an advanced practice role, shifting the self-regulation debate to the more neutral regulatory authority:

Also the issue that we really fell foul of was the Nursing Council role and that was probably the biggest point of disagreement … for NZNO. And what that was about was that we couldn't safely, the rest of the Taskforce, agree to leave the development of the nurse practitioner role in the hands of the Union, who were currently espousing a strong "education is irrelevant and length of practice is what counts"– it just wouldn't have been tenable. So we tried to lift it to a neutral space which was Nursing Council, arguing that we would all then contribute and consult and work with Nursing Council, but at least it would be a safe, neutral territory and of course that's exactly what's happened. But NZNO could not wear that at the outset because it seemed that was a major challenge to their historical authority (the College, p. 3).

The struggle for power to control this important development in nursing was such that it was preferable to shift power to the more 'neutral' Nursing Council, rather than risk it falling into the hands of the union. NZNO maintained the Council was going beyond its jurisdiction into territory belonging instead, to expert clinical

[58] Despite the link to the Medical Council, restrictive trade practices do occur in medicine. A public example occurred in 1996 when the Southland Crown Health Enterprise hired a surgeon from Australia on a short-term contract to reduce the cataract waiting list. The surgery was cancelled when local ophthalmologists refused to provide follow-up treatment (see Ross, 2001). In this case the Medical Council chose to acquiesce to the College of Ophthalmologists.

nurses. NZNO policy analyst Hugh Oliver, described the Council as "dominant and controlling", stating, "[t]o have control over its own future, the profession needs to organise its affairs in ways which are under the control of nurses themselves and autonomous of political pressures" (Oliver, 1998, p. 13). He strongly suggested the existing structures within NZNO, representative of nurses in practice and devoid of political interference, as the place to determine the direction of advanced practice.

These positions illustrate the fundamental difference in values and beliefs between the College (NETS, NENZ and the Council) and the NZNO; between professional autonomy and unionist discourses. Neither of these discourses is mutually exclusive for these organisations, but particular values permit hierarchies where one or other is dominant. The NZNO, however, maintained it was a sham to assert a "dichotomy between professional and industrial issues" (Oliver, 1998, p. 13), as these are entwined with neither privileged. Perhaps, herein lays the difficulty:

> Jill: That's what the whole problem was with the Taskforce Report from NZNOs point of view, that you couldn't separate them.
>
> *That's correct. Couldn't separate union matters, couldn't see it as professional. There was an absolute driver that anything that came – they didn't need the Taskforce – NZNO would solve it. There was a huge grasping for power going on that people actually failed to recognise (NCNZ[3], p. 8).*

This speaker identifies 'grasping for power' as the central issue; because of its dual professional and industrial arms, the NZNO considered itself wholly capable of managing both concerns. Beth Cooper-Leversedge (1998, p. 2) writes following NZNOs withdrawal from the Taskforce:

> At the heart of the matter is a power struggle for the 'mandated' leadership of nursing in New Zealand. This is about ownership of the right to control the destiny of the nursing profession and regrettably, is being communicated incorrectly as a practice – theory gap.

The tension between NZNO and the College reflects their various representations; NZNO (in general) is positioned as "*valuing longstanding hands-on practise"*,

whereas the College (in general) is positioned as "*fostering research and education" (the College, p. 5)*, as well as nurses who are leaders in education and management.

Positioning fundamental differences in ideology as a 'practice – theory gap' is insufficient, however, to explain the clash in power that occurred. Had it been as simple as a practice – theory gap, the competencies for advanced practice would have been the subject of contestation and not the approval body:

> *Nurse practitioner, advanced nursing, was debated at the Taskforce, but the ingredients of that had already been laid down well before then. The issue was never about what do they look like, what do they do? The issue was always about who was the one that was going to approve them. That's the issue that came out of the Taskforce and its still the issue right today with NZNO and the credentialing issue. They would say that they would be the ones to do it (MOH, p. 4).*

The speaker here points out there was little debate about what an advanced nursing role would do, making reference to what had 'been laid down well before then' as the work done by NENZ, in the document on developing and supporting advanced practice roles (Nurse Executives of New Zealand, 1998) and by the Nursing Council on the competencies for advanced nursing practice (NZ Nursing Council, 1998a), published in April and May respectively. The core competencies, appearing in the 1998 Council document, are hardly changed in 2006[59] and indicate that *what* the NP would do was agreed upon; under dispute was *who* would control the role and by what mechanism – statutory regulation or voluntary credentialing.

The argument over who would credential advanced nursing practice was complicated by an amendment to the Health Occupational Registration Acts (HORAA, 1998), read under urgency during the work of the Taskforce[60]. Changes

[59] Two other competencies were added: A first to define the particular scope of practice the nurse was applying to be registered in; and a sixth prescribing competency added in 1999 following the Amendment to the Medicines Act (NZ Nursing Council, 1999).
[60] The principal Act was the Health Occupational Registration Acts Amendment: Amendments to Nurses Act 1977 (1998).

to the nomination of Council members had been signaled in a Ministry of Health discussion document in 1996 (Ministry of Health, 1996). The effect would be to amend the Nurses Act, 1977 and change the nomination process for Nursing Council membership, allowing the Minister of Health to appoint all members. Since the Nurses and Midwives Registration Act, 1925, the NZTNA had the exclusive right to nominate specified Council members. The amendment represented not only a challenge to NZNOs historical power, but in their view, was undemocratic, as well as being "inappropriate to concentrate the direction of professional practice in a very few, politically-appointed hands" (B. Wilson, 1998, p. 2). The affront felt by NZNO leadership was remanent for sometime, illustrated in 2004, when Chris Cottingham (member of *Kai Tiaki's* editorial review committee), recalled the amendment to the Act as a "black day" that "removed any modicum of democracy from the composition of the Council" (Cottingham, 2004, p. 5).

The aim of the amendment was to give registration bodies more autonomy (New Zealand Parliamentary Debates, 1998, June 17) and with respect to the Nursing Council membership, deleted the requirement for the Director General of Health (a doctor or delegate) and the Ministry of Education representative, to be Council members. As French (1998) points out, these changes reflected a reduction in government involvement related to Public Choice Theory, while changes to nominating rights, removed special-interest group capture, ending the longstanding debate over PSA nominations referred to in chapter five. At a time when the Taskforce was recommending the Council regulate advanced practice, the opportunity for the NZNO to influence the Council, via its nominated members, was diminished. The NZNO already had reservations about the Council's role under the Nurses Act to approve programmes of study; now the concern was politicians would, in effect, be in control of nursing education also. In Foucauldian terms, as a regulatory body with functions of surveillance and control of nurses, the Council was itself subject to surveillance and control, not only via external legislation and groups (such as the NZQA), but now also, via internal political means (French, 1998).

The following interview text is an NZNO perspective of how these intersecting and clashing discourses of neoliberalism, unionism and autonomy came into play:

> *Relationships hadn't been good because the College of Nurses Aotearoa, in particular, was if you like, flexing its muscle and saying they wanted to speak on professional behalf and we were tainted because we were industrial. And they had a level of support from the Ministry of Health that was not there for NZNO – even though the membership disparity was huge. Relationships with Council weren't robust at that time either … the other nursing groups thought that a way that they could decrease the power and influence of NZNO would be to give more power to the regulatory body. And we have always been really clear that the regulatory body's role is to protect the public and the profession's role is about the professional development and enhancement and increasing advancing practice – and it should be the profession, in a collaborative way that does that. And at the same time of course the appointment process for Nursing Council was changing and so it was Ministerial appointment and the Minister only has to consult with the profession, he doesn't have to take any notice of them. So we were incredibly anxious about an increasing statutory regulation of nursing which could hinder its development. Now we didn't articulate that particularly well, but when we did it wasn't listened to because it was seen as NZNO is just fighting because they're loosing power… Every time NZNO spoke or voiced a concern about something related to the credentialing of advanced practice it was seen as NZNO being anti-academic, anti-progressive, which is quite the converse when you look at our credentialing programmes and what our Sections do and we do as far as education, development. But that was the perception that was very hard to shake and to raise questions; they were raised in what was an extremely hostile environment (NZNO, p. 5).*

The overall position taken by the NZNO in this text is defensive in relation to the College, the Ministry and Minister of Health and the Nursing Council. The speaker characterises her own organisation somewhat facetiously as contaminated ('tainted') by industrialism, from which the College was at pains to distance itself. Despite its small size, the College was testing its ability ('flexing its muscle') to

speak on behalf of the profession. Expected (historical) support for the NZNO was lacking from the Ministry of Health; and the Minister had taken it upon himself to appoint members to the Nursing Council without reference to the NZNO, if he so chose. The chance to influence the regulation of an advanced nursing role via the nomination process to Council was now undermined, leaving the NZNO 'incredibly anxious' about the impact of potentially inflexible regulation on an advanced nursing role. Existing relationships with the Council are minimised, described as not 'robust' but meaning delicate or weak, yet the willingness to work 'in a collaborative way' with the Council and other organisations, is evident. The speaker rejects the stereotype of 'anti-academic, anti-progressive' and highlights instead, the similarities the NZNO has in credentialing programmes and education development. Because of these similarities and the willingness of NZNO to work with others, the 'extremely hostile environment' was considered unfair and by all accounts, highly taxing. The withdrawal of traditional Ministry support and the technique of distancing from the unionist discourse served to establish a relationship of power that permitted those groups to speak on behalf of nursing and to proceed with Nursing Council regulation of an advanced nursing role.

The withdrawal of NZNO from the Taskforce

At the end of July 1998, NZNO withdrew from the Taskforce and endorsement of the second draft of the report. In *Kai Tiaki's* August editorial, Brenda Wilson outlined the reasons for withdrawing, citing the lack of open debate over the composition, timeframe and consultation aspects of the report[61] (B. Wilson, 1998). These too, were criticised by Marie Crowe in a letter to the editor of *Kai Tiaki*:

> The original taskforce did not appear to be genuinely representative of nursing and its timeframe possibly hindered a genuinely representative consultation process. The speed with which the taskforce chose to proceed and the lack of acknowledgement of the views presented by the NZNO suggest a lack of genuine collaborative effort (Crowe, 1998, p. 3).

[61] Not all NZNO nurses received the questionnaires sent out by the Taskforce in the March issue of *Kai Tiaki* due to an erratic printer insertion problem, raising the question of validity of the Taskforce's findings (Bexley, 1998; Gracez, 1998).

Reflecting a unionist discourse from the outset, NZNO had maintained that nurses' pay, terms and conditions of employment, patient safety and skill mix, access to post-registration education, funding and contracting of health and disability services could not be divorced from the identification of barriers and strategies to enhance nursing practice. According to Wilson (1998), these issues in the NZNO submission were absent from the first draft and minimally present in the second. Yet all of these issues were addressed in the report in the chapter on 'Workforce Resourcing' and others on 'Education' and 'Access to Funding'. However, Wilson maintained they had been omitted, as had the impact of the Employment Contracts Act, 1991, and represented too great a departure from NZNO principles and policies to continue to be involved. Missing an opportunity for consensus, the result was not only a lack of buy-in to the final report, but the release of an alternate vision for the future in a document called *Building Partnerships* (NZ Nurses Organisation, 1998, September). Any risk of the Taskforce report becoming obscure was ameliorated by the very public display of discord when the NZNO withdrew from the Taskforce team; the consequence of which brought far greater attention to the Taskforce findings than might otherwise have occurred. Nonetheless, an immensely more productive approach for nursing politics in New Zealand, at the time, may have been one of compromise between all parties.

The public nature of NZNOs withdrawal from the Taskforce is characterised in a *Kai Tiaki* editorial in battle terms and the conflict is rationalised as a normal sign of a 'mature profession':

> To pretend there is no conflict within the profession, or that any such conflict should occur behind closed doors, is an insult to a robust profession. A mature profession should be able to easily withstand, and grow from, such dissension in its ranks (O'Connor, 1998, p. 2[62]).

[62] Anne Manchester and Teresa O'Connor are the co-editors of *Kai Tiaki* and from time to time throughout this thesis their editorial articles are referred to. It is important to note that while O'Connor is a nurse, both her and Manchester write from a journalistic perspective that is often based on a degree of controversy. The editorial review committee comprised of nurse academics and nurses from practice have no jurisdiction over editorial or viewpoint articles published. While I have commented on the ability of Hester Maclean, as the original owner and editor of *Kai Tiaki,* to both control and circulate the dominant discourse of nursing at the time, this power now lies not with nurses, but with journalists, raising issues about who has the power to 'write' nursing.

The reference to 'ranks' in this text draws on a unionist discourse and positions nurses in the 'rank and file' imagery of enlisted troops and as regular workers collectively withstanding an assault. Perhaps the potential to 'grow from' the challenge and exchange of ideas is a legitimate aspiration, had the conflict remained 'behind closed doors', but its open nature may well have undermined the credibility of nursing to manage its own affairs in the eyes of the public and of medicine. Doctors traditionally 'close ranks' to work together on a particular problem, affording a strong and unified defense of its chosen position:

> *I think the other trouble with docs is they do their arguing behind closed doors – which on one hand I have appreciated because nursing goes public and shoots each other to death – they don't. By the same token, that means they toe the party line. So I know that there are docs out there that support this [NP role] but they can't say because their colleagues will be cross. So it works against us again, you see (NCNZ[3], p. 15).*

This interview text identifies the closed ranks approach taken by medicine to the introduction of advanced nursing practice, acknowledging the compromise required for many doctors who have to 'toe the party line'. A unified position for medicine is one of strength and works against nurses when they are in a divided position. For example, a news and events story about the newly established working groups on prescribing in *Kai Tiaki,* expressed shared NZMA and NZNO concern about the Taskforce findings, stating "We wanted to let the NZMA know we were not interested in doctor bashing and that we wanted to work cooperatively with all health professionals" ("Work starts on prescribing," 1998, p. 9). Closing ranks with medicine thus became a strategy to strengthen NZNOs decision to withdraw from the Taskforce.

Constructing consensus

A literature review commissioned by NETS on advanced nursing practice had identified "a tabula rasa window of opportunity for nursing to learn from the experiences of other countries" (Holloway, 1998, p. 23), particularly in relation to master's level preparation, legislative protection for the role, title and scope of practice and nursing collaboration on the development of national standards. A three-day workshop in March 1999, hosted by the College of Nurses and held in

Palmerston North, aimed to develop guidelines that would address these issues and underpin the development of advanced practice roles in New Zealand. One hundred and thirty-five nurses attended from a broad cross-section of practice and policy areas, the majority of whom were NZNO or College members (T. Smith, 1999). By then, tertiary institutions were starting to develop advanced nursing practice programmes and working parties on prescribing authority for nurses had been established. No nationally consistent title for advanced nursing practice had been decided upon and the situation prior to the Taskforce of a proliferation of nursing titles and roles continued. Issues for which consensus was sought were: nationally consistent titles; the level of education for advanced nursing practice; the location of prescribing authority; how advanced nursing roles would differ from medicine; and which body would do the credentialing. The Workshop proceedings summarised the issues the profession agreed upon and the issues around which some tension and disagreement remained ("Work in progress," 1999).

Referred to as a decision-making workshop (Jacobs, 1999; T. Smith, 1999; "Work in progress," 1999), NZNO stated the purpose of its participation was to "take information back to its members for discussion" (Cain, 1999, p. 27). However, decisions were voted on by those present and actioned as a result of the workshop. The following interview text highlights the discourses of autonomy and unionism that were fundamentally at odds with one another, as one sought professional self-determination via dialogue and decision-making, and the other via consultation with members not present:

> *It was a College of Nurses hosted conference and it had a very loose agenda. Well, it had a very loose programme; it had a very clear agenda, which was to push in a certain direction around nurse practitioners. There were about 112 there if I recall correctly and there were four [staff] from NZNO … In the first day there were these workshops, there were no papers, so a lot of the contextual stuff was missing from the discussions of those workshops. And we came back into plenary session and suddenly there was this call, "Well we'll vote on these things, ideas and concepts" to which [we] said, "We can't do this. This is not a decision-making body."*

…

Jill: There were two lists; things that were agreed on and things that remained contentious.

We wouldn't have agreed. It's just not in fitting with the processes within our organisation. We would never; we have no authority … as staff members to say that we would commit to a policy. It is not the way our organisation works (NZNO, p. 17).

The speaker begins by suggesting the College as host had pre-determined the direction the workshop would take. Consensus was sought by way of a vote. Making policy decisions based on the small number of nurses present was anathema to union democratic practices and because of the conflicting position NZNO representatives were placed in, this participant earlier in the interview described the workshop experience as "*Oh, it was awful, it was terrible*" *(p. 16)*. Group decision-making processes can occur in two ways; by general agreement (consensus), or by vote. Generally these terms are made clear from the outset of a meeting. When consensus is slow to come and a vote announced, power is exercised to silence the minority dissenting opinion. While ostensibly democratic, Mill (1975, p. 24), in his essay on liberty, cautions that "[a]ll silencing of discussion is an assumption of infallibility".

All the same, the union perspective was not altogether over-shadowed by the workshop and in fact, complemented discourses of autonomy in the following statement which identified remaining key challenges:

> There is concern within the profession that nurses will be asked to provide an expanded service without reimbursement commensurate with the increased level of responsibility, the personal investment in education and the need for ongoing professional development which will be integral to advanced practice roles … we need to clarify that advanced practice roles are not simply a less expensive substitution for medicine. Rather, advanced practice nursing is about providing some services more cheaply, providing others that are currently overlooked, and co-ordinating more effectively some of the fragmented care which is already provided ("Work in progress," 1999, p. 14).

Autonomy, in this statement, is evident in the desire to address a health agenda with an advanced practice role, but not without remuneration commensurate to the expanded service and personal investment in education. Of all statements contained in the proceedings document, this statement does reflect a consensus of the two previously conflicting positions. Determination to overcome differing positions and work together strategically did ensue during the coming year, although the increasing role and function of the Nursing Council remained problematic for the NZNO.

Considerable discussion at the decision-making workshop occurred about where the responsibility for credentialing an advanced practice role should lie, particularly in light of disagreement over this issue following the Taskforce report. The conference proceedings stated that "In general it was agreed that the Nursing Council should co-ordinate and manage the credentialing process with the professional organisations" ("Work in progress," 1999, p. 11). Those present also endorsed the continued refinement of the Nursing Council framework, guidelines and competencies for post-registration nursing education (1998a). The rationale for the Council taking responsibility for credentialing has already been examined, but disquiet even among Council members remained:

> *[The Council had] taken on more of a leadership role in professional matters than you normally would …no one would because everyone was fighting. I decided that we were this wonderful neutral body that's pulled together from everywhere that shouldn't have an axe to grind, that therefore we would go and get the documents going like the advanced nurse practitioner and the advanced education model. And that no one else was doing it. In my heart of hearts, I know Nursing Council shouldn't have done it because it's not Nursing Council's role. Nursing Council is for public safety. I convinced myself that if we had those documents then the public would be safer. I knew that's Nursing Council's role – public safety, put people on the register, off the register – and the professional side was done by nursing organisations. But they weren't doing it, pure and simple and I make no apology for it (NCNZ[3], p. 7).*

The speaker in this text acknowledges that developing an advanced nursing practice role and education model was beyond the Nursing Council's jurisdiction, but justified its involvement on the grounds that 'no one else was doing it'. Characterising itself as 'this wonderful neutral body' suggests an impartiality that at best, is highly speculative. The semblance of neutrality in this instance was a powerful strategy to take 'a leadership role in professional matters' and overcome the divisions within nursing that were constraining the profession's development.

Reflecting on the role the Nursing Council undertook, the following participant recalls the divisions within nursing at the time and positions them specifically as a 'unionist stance' and a 'professional advocacy stance':

> *How did we arrive there [with the Nursing Council regulating the NP]? … To me it was a Council forum that really put a stake in the sand that we never re-visited. And it was one in Wellington, probably about five or six years ago[63], could even be longer. And at the time all this prescribing and NP work was starting the Council wanted to know if they should continue this work or if the professions would be the better place to locate it. At the time the profession was somewhat splintered between those who took a more unionist stance and those who took a more professional advocacy stance. The groups were not strong and the voice back to Council was, "You continue to manage and broker that for us". And it was never revisited. So the profession, albeit an unrepresentative, ad hoc, consultative voice that was present there … gave the Council license to continue its work that way and to act as an agent that drew in the profession to advise it, take the responsibility that was actually beyond its regulatory mandate (Nurse academic, p. 16).*

The speaker reiterates the idea from the previous interview text that because the groups were 'splintered', the Nursing Council, by default rather than design, took on regulation of the NP role. The terms 'broker' and 'agent' are used suggesting the Council could best represent the interests of nursing – a task that does normally fall to the professional organisations. Interestingly, the Nursing

[63] Most likely October 1999

Council's "means of bringing power relations into being" (Foucault, 1983b, p. 223) was to defer to the profession's wishes, but one could equally say, to take control at a time when the profession was most vulnerable. The decision was never 're-visited' and may well have related to the anticipated revision of the Nurses Act, 1977 and the potential to include an advanced nursing role in new legislation.

Concern about the lack of preparedness of the Council to take on credentialing of an advanced role and bolstered by the ICN position on professional self-regulation, the NZNO invited the other nursing organisations to work together on a unified model where together they would do the credentialing for advanced nursing practice (see Trim, 2004b):

> *And at the end of the day there was a meeting between the College, the Nurse Execs and the NZNO and we agreed to a broad strategy for moving forward together and then later on the College of Mental of Health Nurses came in and the Council of Māori Nurses. What we worked on was drawing out the proposal where we [the professional organisations] would do the credentialing and we worked in great detail through the process: what ifs; how would we assess educational equivalence etc. And at the end of the weekend the working party invited Judy Kilpatrick, who was the chair of the Nursing Council at that time, to the meeting and to hear our work and to give us some initial feedback and responses. She thought that what we were doing was great. Was very encouraging but she didn't think that Nursing Council could relinquish control of credentialing. We continued to work on a proposal but we really took out that we would do the credentialing but we would have oversight of the processes, criteria and application. And we presented that proposal to Nursing Council and Nursing Council couldn't accept it. But it was the opening ground for us to work on what eventuated as NPAC-NZ (NZNO, p. 11).*

The NZNO had developed considerable credentialing mechanism expertise through its own processes and remained optimistic about working collaboratively with the other nursing organisations to carry out the credentialing of advanced

nursing practice, in lieu of the Council. A last ditch attempt, it failed to gain Council approval, yet formed the basis for an alternative structure to address the concerns of these organisations, the NZNO-led, Nurse Practitioner Advisory Council of New Zealand (NPAC-NZ). According to Trim (2002, p. 27), this committee, established in July 2002, was the "first major collaborative venture between the five organisations … for the future development of the nurse practitioner model". The role of NPAC-NZ is discussed further in chapter ten.

Role roll-out

Following the election of a Labour-led coalition government in 1999 the new Minister of Health bolstered the development of an advanced nursing practice role with considerable political sponsorship, envisioning nurse practitioners to be "ideally placed" to provide services under the newly developed PHC Strategy (Hon Annette King in Ministry of Health, 2002, p. iii). The Ministry of Health's Chief Nursing Advisor, Frances Hughes, the Nursing Council and Professor Jenny Carryer worked to develop a model for New Zealand, based on the research of Hughes on advanced nursing practice in the US and the international evidence in support of the role (Ministry of Health, 2002). A blend, based principally on the United States model of nurse practitioner and clinical nurse specialist, was adapted for the New Zealand model, enabling nurses to be endorsed in their specialty at their chosen level of primary, secondary or tertiary care. Nurse practitioners were expected to be independent and collaborative, crossing the hospital/community interface, to provide assessment, intervention, health promotion and disease management, including diagnostic testing and prescribing (Ministry of Health, 2002).

A joint statement released by the Nursing Council and Ministry of Health in May 2001, announced the new nursing qualification. The Nursing Council would formally regulate the role, set advanced nursing competencies, including those for prescribing, and monitor the master's level education programmes (Ministry of Health, 2001, May 15). Following the launch of the document *Nurse Practitioners in New Zealand* in July 2002 by the Minister of Health, a series of road shows were held throughout the country to present information to health providers about how the role could be implemented (F. Hughes, 2003, June). The first nurse

practitioner, Deborah Harris, was credentialed in December 2001 ("First nurse practitioner appointed," 2002).

The introduction of the Employment Relations Act, 2000 brought about important changes within the NZNO. The Act restored the role of unions nationally in promoting their members' collective employment interests and along with a change in leadership within the organisation, softened the NZNOs militant position to bring a renewed focus to the representation of professional issues. Successive position statements made by the NZNO on advanced nursing practice illustrate a shift towards acceptance of the Taskforce recommendations. For example, a statement made in 2000, supported educational preparation at master's level, stating that "Being an expert-by-experience in a specialty is not on its own sufficient for advanced nursing practice" (NZ Nurses Organisation, 2000, June, para. 4). Recognition of the role in the statement, however, was to be by "professional self-regulation through the professional associations and not through statute" (para. 14). Following the announcement in October 2000 that the Nursing Council would regulate the role, the NZNO position statement was revised to state, as a matter of fact, the Council's role in regulation (NZ Nurses Organisation, 2003, August).

Although the official NZNO position on the conditions for a nurse practitioner role began to align with that of the Nursing Council and Ministry of Health, considerable residual resistance amongst the membership is recorded in articles and letters to the editor in *Kai Tiaki* (see Pantano, 2003; Pepperell, 2003). A case in point is that of Marg Eckhoff, whose application for nurse practitioner endorsement was turned down twice because of problems with educational equivalency. She is quoted as saying:

> I think there are a lot of academic nurses having a lot of say in the direction of the profession. I think they've lost the plot – lost contact with clinical nursing. It is the people on the ground who really understand and I feel those academic nurses are looking down on us. I'd like to say to them 'come and try my job for a while' (O'Connor, 2003a).

Echhoff later wrote to the editor of *Kai Tiaki,* overwhelmed by the support from New Zealand nurses, and thanked those who had written to her and to the magazine (for example, Baillie, 2003). O'Connor (2003b, p. 13) summarises the common threads found in the articles and letters to *Kai Tiaki*:

> that nurses who want to advance academically and those who want to remain in practice, learning through on-the-job study, should be equally valued; that nurses who have been working at an advanced level of practice for years, some of whom have been called NP, are feeling frustrated and disillusioned; that the NP role may create divisions within the profession; that those driving advanced nursing practice are out of touch with the reality of clinical practice.

These concerns of elitist education creating divisions within the profession are firmly embedded within the unionist discourse and were represented by the NZNO throughout the work of the Taskforce. These anxieties have resonance with the reaction to the introduction of comprehensive nursing education in the 1970s and the fear that hospital trained nurses would no longer be valued (Geoff Annals, CEO of NZNO in O'Connor, 2003b). As was the case at that time, discourses of autonomy and academia produced effects of domination achieved by the position of power held by those speaking and the institutions they represent (Foucault, 1990). Evidence of an incomplete shift from 'learning through on-the-job study' towards an academic preparation remains some thirty-five years later, raising questions about how embedded academic inquiry is to nursing practice.

Summary

This chapter has examined the clash of particular discourses as the construction of the *most* expert nurse became the locus of a struggle within nursing to control its future development. In the constitution and recommendations of the Taskforce, discourses of autonomy partnered with those of academia and neoliberalism to exclude a unionist discourse and position the nurse practitioner role within a state-sponsored regulatory framework. Nursing has been variously represented by these discourses and, as with the competent nurse, variously constituted by both regulatory and educational practices.

The practices that constitute the *most* expert nurse are the same as those that constitute the competent nurse; education and regulation (see chapter six). Surveillance by the Nursing Council of educational institutions is maintained, with particular programmes needing to meet the approval requirements of nurse practitioner pathways. Educational practices, however, are at master's level and focus on individual knowledge development and academic discipline in critical analysis. The nurse practitioner is constituted by the same regulatory practices of examinable competence required of registered nurses, but his or her portfolio is subject not only to *random* audit, but intense scrutiny throughout each applicant's credentialing process. The portfolio is the inscribed detail of a nurse's practice, rendered visible to the gaze of the Nursing Council and the interview panel of peers. As effects of power, these practices construct nurse practitioners as knowledgeable and autonomous, empowered by their peers and the state, to practise independently in their chosen area of specialty. Thus constituted, there is an indirect implication of exclusion of some other groups (Sarup, 1996), to which there is inevitable resistance.

Sarap (1996, p. 75) has to say of Foucault, "It is generally believed that he is not interested in who has power" and this chapter has dwelt on which discourse, rather than particular individuals, held power. However, as has always been so in nursing, an effect of individuals holding office across a number of closely related institutions facilitated the dominance of particular discourses, those of academia and autonomy, in the construction of the nurse practitioner. These relationships were most evident in the membership of the Ministerial Taskforce on Nursing and have continued through subsequent phases of role development.

In the articulation of a nurse practitioner's scope of nursing practice, however, (nurse practitioner competency number one: NZ Nursing Council, 2004b), another construction occurs that is unique to the practitioner; education informs his or her practice and regulation controls its shape, but it is how those practices combine with practice experience and ability that constructs a nurse practitioner to achieve "authority over the nature of their practice" (Nurse Executives of New Zealand, 1998, p. 1).

These chapters on the political discourses inside and outside of nursing and the construction of the competent and *most* expert nurse have outlined the dominant discourses that have created an interstice for the nurse practitioner role in New Zealand. Part three of the thesis addresses the discourses that prevail for the nurse practitioner as he or she practises in the interstices and the possibilities for a new and more liberating mode of subjectivity.

Part Three: Practising in the interstice

The final part of the thesis consists of four chapters. Part two surveyed one hundred years of nursing in the 20th century; part three is concerned with the context of nurse practitioner development in the 21st century. Reintroducing Foucault's notion of governmentality, chapter eight begins by examining the business model of general practitioner proprietorship in the context of a new government regime, introduced with the PHC Strategy (Ministry of Health, 2001b). It is argued, the for-profit imperative of GP ownership continues to view PHC as curative medicine, constraining the expansion of nursing practice into population health and the nurse practitioner, as a potential business competitor, into assessment, diagnosis and prescribing practices.

Chapter nine examines the basis for medical resistance to the introduction of prescriptive privileges for nurse practitioners and the protracted journey of negotiations that took place to bring about the necessary legislative change. Of interest are the disciplinary practices used by a group of specialist physicians to curtail nurse practitioner autonomy and independence by limiting prescriptive powers.

Chapter ten foregrounds the representations of New Zealand nurse practitioners as a new and more liberating mode of subjectivity. Foucauldian theoretical tools of 'techniques of the self' are introduced as a mechanism by which nurses engage in new techniques of self-governance. Nurse practitioners actively constitute themselves as safe prescribers, collaborative practitioners and as trustworthy colleagues, ushering in hope for a new normalcy towards trust between the two professional groups. As a new mode of subjectivity, the nurse practitioner identity is not defined by the truth claims of others – as nursing has (Papps, 1997) – but by a *nursing* discourse and *nursing* practices informed by multiple forms of knowledge, only one of which is medicine.

The final chapter to the thesis is the conclusion and draws together the main arguments presented throughout parts two and three. The limitations of the study, implications for further research and suggestions for the future are discussed.

Chapter 8: Medical privilege

Introduction

> "It's turf, turf, turf," says Art Caplan, a University of Minnesota medical ethicist …"The resistance is dressed up in language about inadequate training, inappropriate preparation and lack of skills, but the bottom line is that it's a fight over turf. Authority and prestige are the issues". Further, he adds, "rattling in the background are the bones of about 100 years of sexism, in which nurses were basically mistreated, under appreciated, taken for granted and viewed by too many doctors as being third-rate citizens doing fourth-rate jobs" (cited in Cimons, 1993 June 28, p. 1).

This chapter examines the dominance of medicine in the delivery of health services in New Zealand. The privileged position of medicine dates back to the late 19th century practice of professional men in independent practice charging, at their discretion, a fee for service (Belgrave, 1991). As state funding streams developed under the welfare state during the 1940s, only medical practitioners were eligible for payment, as by omission, policies excluded non-physician providers from reimbursement (see Fairman, 2003). Legislative state practices, too, have privileged medicine with particular powers in relation, for example, to public health (Health Act, 1956), access to medicines (Medicines Act, 1981), provision of death certificates (Coroners Act, 1988) and sick certificates (Holidays Act, 2003). Together they form a network of power to construct a discourse of medical ownership that is sanctioned by the state (Freidson, 1970).

New interpretations of health and service delivery introduced under the PHC Strategy (2001) in many respects challenged the privilege of medicine and positioned nurses as the largest and often most appropriately prepared workforce to expand into areas such as population health and primary health care. But it is argued new nursing ventures are constrained by the business model of primary medical care delivery and discourses related to profitability. Advanced nursing roles into areas beyond the direct gaze of medicine, along with the permeability of boundaries between the professions of nurse practitioner and general practitioner, represent a competitive threat to the monopoly and profitability of the business model.

Whereas part two of this thesis concerned autonomy as a discourse in relation to the expansion of nursing practice, this chapter first considers the autonomy engendered as a practice of neoliberalism in the governance of health service provision in New Zealand and secondly, autonomous nursing practice as *fait accompli*. The discussion is focused on primary and not secondary or tertiary care services, because the nurse practitioner role is potentially most threatening to the jurisdiction of general practitioners rather than specialists, excepting the anaesthetists (examined in chapter nine).

Foucault's (1991b) notion of governmentality will be used throughout the chapter to illustrate the range of techniques available for governing. Government has as its purpose "the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health etc." (Foucault, 1991b, p. 100) and to achieve those ends an ensemble of disciplinary techniques (surveillance, examination and normalisation), domination and government of others and the self may be used. Domination may be the end effect, but the means by which this is achieved is not, in the first instance, by force, although that is a possibility. The PHC Strategy is a government technique that locates responsibility for the welfare of the population through the provision of health services with DHBs, PHOs and health practitioners, in both morally responsible and economically rational ways. Governmentality, therefore, harnesses and directs these groups, including nurses, towards particular behaviours that coincide with a government programme. As previous primary care identities disintegrate with new forms of organisations such as PHOs, new modes of subjectivity are produced that are linked to governmental technologies (Lemke, 2000); an example discussed in this chapter, is the state sponsored initiative integral to the success of the Strategy that introduced the nurse practitioner role.

This chapter, therefore, examines the relations of power engendered by the introduction of the PHC Strategy, between physicians and the state, and physicians and nurses. General practitioner ownership is highlighted as the context in which nurses aspiring to become nurse practitioners must find an interstice in which to practise, between conventional medical and nursing role boundaries.

A discourse of ownership

Within the small business model of general practitioner proprietorship, this chapter refers to a discourse of ownership and identifies two systems of discursive practices. Firstly *business* practices that are related to proprietorship and a profit imperative, the right to collect a fee-for-service via state subsidy (with or without co-payment), enrolment practices that ensure patient loyalty and secure state funds, vicarious liability related to employees and risk management; and secondly *clinical* practices that are concerned with the autonomy of a doctor in clinical decision-making, in diagnosis and prescribing and the traditional authority of a doctor to direct the practice of employees. Within this discourse, maintaining autonomy in governance from central government is a priority (except for compliance with conditions for payment of state subsidies) and produces a strong motivation for control of issues that impact on either business or clinical practices, in order to preserve a market monopoly in the provision of primary care services. The term 'market' is used advisedly to highlight the commodification of health care operating as a practice of a neoliberal regime.

'Primary *health* care' is distinguished from the term 'primary care'; the former broadly embracing the social determinants of health (as defined by the Alma Ata Declaration, 1978), and the later being mostly confined to curative medicine provided by physicians in non-hospital settings such as general medical practices, or (ironically) health centres. Shaw (1986, p. 12) identified the confusing and incorrect perception that "primary health care is seen as primary *medical* care by many providers and consumers" and the inadvertent interchange of the terms in policy documents has led to the assumption that general practitioners have governance over both. Importantly, primary health care has created a space that nurses working in primary care can appropriate.

A discourse of ownership produces various subject positions for general practitioner owners, nurses employed by the practice and clients of the practice. For the GP owner, he or she is positioned as responsible for both the business and clinical discursive practices described above and with the reciprocal and defended rights to privilege and social prestige, and usually a generous income. On average,

a general practitioner owner can expect to earn NZ$150,662 net profit return on investment before payment of salary or benefits (Waikato Management School, 2006)[64]. This compares with a New Zealand average income of $30,482 before tax (Statistics New Zealand, 2005, June).

For nurse employees of a general practitioner, he or she is positioned as responsible for the delegated tasks assigned by the employer, for which the GP is vicariously liable and the nurse professionally accountable. In turn, employees are entitled to fair remuneration. A registered nurse working in a DHB earns a top rate of $54,000 before tax, while practice nurses have earned approximately $44,000 (NZ Nurses Organisation, 2006, June). A NZNO campaign during 2006 has been to reach a multi-employer collective agreement and achieve parity in pay and conditions between nurses in the primary sector and nurses working for a DHB. Costs associated with professional development and study leave are either met by the employer or individual nurse. Recognising that practice nurses have had little access to postgraduate education, primary health care nursing scholarships have been available from the Ministry of Health since 2003. The new PHC multi-employer collective agreement ensures 40 hours paid professional development leave per year (NZ Nurses Organisation and NZ Medical Association, 2006, December).

The practice of naming clients of the practice as 'patients' positions people within a bio-medical understanding of health, located in a dependent and sick relationship to medicine, rather than empowered and well. Activities usually undertaken by nurses relating to health promotion and wellness maintenance are marginalised, but importantly, naming people as patients reiterates the notion of individuals 'belonging' to particular doctors. It is these naming practices that serve to position patients as objects or possessions for which a doctor then assumes responsibility. Naming patients as 'clients' makes little difference other than to reaffirm the business relationship, although there is a reciprocal entitlement to services of a reasonable standard. Whatever the nomenclature –

[64] The sample consisted of 79 participating general practices.

patients, clients, consumers, or enrollees – all pay for services rendered, albeit at the discretion of the doctor (Tilyard, Gurr, Dovey, & Krebs, 2006).

A new regime

In 1999, the incoming third Labour government, in many ways, challenged the business practices of general practitioner proprietorship by reconfiguring primary care under the PHC Strategy (Ministry of Health, 2001b). As the national funding, regulating, policy advice and monitoring agency, the Ministry of Health's understanding of primary health care drew on expert international discourses of "promotive, preventative, curative and rehabilitative" health services and the associated discursive practices of education, immunisation, hygiene and appropriate pharmaco-therapy referred to in the Alma Ata declaration (World Health Organization, 1978, p. 2). The PHC Strategy's (2001) definition of primary health care was based explicitly on the Alma Ata declaration (a portion of which is included as appendix two of the Strategy document), and therefore, reflected a clear commitment to health care that went beyond curative medicine to address population health needs and thus shift the interest of health practitioners, who secure government funding, towards a similar understanding.

As a technique of government, the PHC Strategy (2001b) is a project that endeavours to "administer the lives of others in the light of conceptions of what is good, healthy, normal, virtuous, efficient, or profitable" (Rose & Miller, 1992, p. 175). A body of knowledge derived, in this case, from World Health Organisation expertise, is central to the construction of a discourse through which the government attains the agreement of the population to make a change (Naughton, 2005). That is, a case is made for positive change towards maintaining population wellness, being more than the existing curative focus of primary care services. A regime of truth is thus established and becomes an instrument of power to which health practitioners become subject and are expected to adjust their conduct accordingly.

The new regime was introduced to the general practitioner community in a speech given by the Associate Minister of Health, Tariana Turia, to GP delegates attending a CME conference at Wairakei, in 2001. Changes to general practice

arising from the newly developed PHC Strategy were announced but greeted with considerable hostility. The following text is an excerpt of the Associate Minister's speech as reported in *NZ Doctor*[65] and is followed by a response in the same article from the Chairperson of an IPA management company, Dr Tom Marshall:

> Will IPAs be allowed to continue to evolve, will all copayments go and will nurse practitioners relegate doctors to a minor trafficking role in primary care? Many GPs were rattled and unsettled by Ms Turia's comments pertaining to the new PHC Strategy, in particular, to the formation of primary health organisations (PHOs). She says to achieve the Government's goals, 'doctor dominated care delivery' must change to a team approach… Perhaps the crux of the anxiety from those gathered stemmed from the comment the strategy will also require health professionals to change the way they deliver care and manage their practices. Ms Turia says there is international evidence primary health care nurses can provide first contact primary clinical care as safely, effectively and with as much satisfaction to patients as a GP. "The development of nurse practitioners will provide a key interface role in the primary care sector and also between primary and secondary sectors." At the same time, GPs are being called upon to treat more complicated cases and coordinate care of these complex cases with speciality providers and community support agencies"
>
> …
>
> Copayment champion and ProCare boss Tom Marshall was clearly angered by the speech and launched an attack on the associate minister. "I am absolutely appalled at parts of your speech. We have heard platitudes, then you waded in to talk about doctor dominated organisations. We talk about doctor-led organisations because that is what we do. To tell us our work can be done as well by a nurse practitioner is the biggest kick in the teeth you can give us. Parts of your strategy are unworkable and unthinkable to GPs" (Hill, 2001).

[65] Excerpts in the report from the Associate Minister's speech are accurate. See Turia (2001) for the complete record.

The excerpt begins with three questions asked by the reporter that are rhetorical in the sense they are not specifically answered in the remainder of the report. For the reader they lend weight to the overriding perception that the PHC Strategy will undermine GP autonomy ('will IPAs be *allowed* to continue'; 'will all co-payments go'?). In the third question, irony is used to portray an image of doctors reduced to drug-peddling petty criminals ('minor trafficking role') because the increasing role of nurse practitioners in PHC (as the report later identifies) will, by implication, leave doctors little else to do other than write prescriptions. Riggins (1997, p. 8) would describe this technique as a victim-victimiser reversal where "members of a dominant majority, historically part of a class of victimizers, claim they are being victimized by attempts to achieve social justice".

The Associate Minister of Health draws attention to the 'Government's goals' and suggests these are not consistent with 'doctor dominated care delivery'. She contrasts the 'team approach' to existing delivery models stating there must be a change. In so saying, the Minister is signalling a shift from primary care services that suit the (business) goals of doctors, to primary care services that are inclusive of consumers and other health team members (the 'team'). Furthermore, the governance of PHC will shift from individual GP practices to government agents, (the PHOs) and involve community representation in their governance structures. Understandably, the terms 'rattled, 'unsettled' and anxious ('anxiety') are used to describe the response of GPs to this challenge to their sovereignty from the state.

The next challenge presented to the GP delegates is that of a potential business competitor in PHC, the nurse practitioner. Discussions about an advanced practice role for nurses in New Zealand had been well underway for some time (see chapter seven) and formal announcements by the Ministry of Health and Nursing Council about the nurse practitioner role were made earlier in the year (Ministry of Health, 2001, May 15). Other media releases by the NZMA and in *NZ Doctor* were substantially negative about the role ("Concern over new nurse job," 2001; St John, 2001; Fountain, 2001). Thus many delegates may have already framed nurse practitioners as a potential threat. To have the Associate Minister of Health (and therefore the weight of Cabinet) citing international evidence and publicly endorsing a nursing role in PHC to be as effective as a medical role, was

particularly provocative (see below). The effect is mitigated somewhat as the Minister elaborates on the need for GPs to treat the more 'complicated cases'.

The desire to preserve the status quo is expressed by the Chair of ProCare (an IPA management company), who is so 'angry' and 'absolutely appalled' by the speech that, illustrated by a battle metaphor, he 'launches his own attack'. He is scornful of the Minister's initial banalities, but especially her decision to 'wade in' and challenge doctor dominated/led organisations implying she is wading in out of her depth to a situation she knows nothing about. On the one hand, a formidable force to be reckoned with, GPs are next portrayed as victims, 'kicked in the teeth' and insulted by the suggestion that a *nurse* could do as good a job as a doctor. He justifies his outrage by drawing on the social norm of seeing not a nurse, but a doctor for health related issues. Although speculation, his understanding of the nurse practitioner, particularly in 2001, is not likely to be based on the expert clinician who is master's prepared, but the many practice nurses who have been disadvantaged in terms of professional development in the business model of primary care practice[66]. The challenge issued by the Minister's speech to business autonomy and clinical monopoly is confronted by Dr Marshall, who exercises his right to withdraw GPs from cooperation with the government, on the basis of an 'unworkable' and 'unthinkable' strategy.

A government ideology that encourages nurses to move into a more active role in PHC and GPs towards more 'complex cases with speciality providers' is a favourable situation for nursing (Larson, 1977). Christensen, Bohmer and Kenagy (2000) would describe the opportunity as reflecting the natural up-market migrations intrinsic to economic progress that are characteristic of 'disruptive innovations'. Not new innovations, disruptive innovations are the cheaper, more convenient and simple solutions or services that meet the needs of the majority of customers while more advanced technology serves the needs of fewer, but expensive and high-need customers. When applied to health care, disruptive innovations can be the 'simple' technologies of primary health care such as health

[66] Kent, Horsburgh, Lay-Yee, Davis and Pearson (2005) report in a sample of 194 practice nurses, 10 had an undergraduate degree and none had postgraduate qualifications other than professional practice development certificates.

education and immunisations that meets many of the needs of the majority. When delivered by expensive and specialised professionals, however, PHC interventions are not cost-effective for either consumer or provider, leaving many consumers without proper care. Thus less expensively trained professionals 'sneak in from below' to take on services left behind by specialised professionals, as specialists engage in increasingly more complex technology to cure the sickest of patients (Christensen et al., 2000).

Ironically, the "desire of physicians to preserve their traditional market hegemony" has "forced highly trained physicians down-market" (Christensen et al., 2000, p. 108) and prevented less-expensively trained professionals, such as nurses, from moving 'up-market' into skills they can do perfectly well. To preserve their livelihood, primary care physicians must see more and more 'low-tech' cases, spending less and less time on individual clients. Variously referred to as 'technology transfer' (Health Workforce Advisory Committee [HWAC], 2005) and 'bump chains', Abbott (1988, p. 89) notes this kind of "jurisdictional change invokes interprofessional contests" and the wielding of institutional power to preserve the status quo (Christensen et al., 2000).

In a discussion of resources that are at the disposal of a profession to secure market control, Larson (1977, p. 48) points out "the more a profession's particular ideology coincides with the dominant ideological structures, the more favourable the situation is for a profession". Such has been the long-standing case for medicine, but the new regime of cost-effective and equitable access to primary *health* care under the PHC Strategy has led to considerable more support for nursing to move 'up-market'. Nursing in turn, draws on a primary health care nursing discourse to position nurses prominently within this ideology, much to the chagrin of medicine.

The business model of health

The PHC Strategy was originally modeled on the community iwi primary care organisations that had flourished during the 1990s and drew on a discourse of community participation in governance. The Strategy provided for the establishment of community not-for-profit trusts to be called Primary Health

Organisations. Funding was based on a capitation formula paid by DHBs to PHOs for the provision of services that met local population needs. Comprised of a broad range of health professionals including nurses, nurse practitioners, general practitioners, physiotherapists, dieticians and pharmacists, the requirement to spread governance amongst these professionals and community representatives suggested an agenda that would shift the emphasis from fiscal medicine to social medicine; from curative medicine to population health. The Strategy required patients to be enrolled with a GP in order for that GP to receive funding calculated on per capita enrolments. The intention of wide-scale population-based funding was to improve population health by moving away from fee-for-service payments and user co-payment, which encouraged episodic treatment for illness (Ministry of Health, 2001b).

Two main types of PHO have developed, however, with distinctly different characteristics and ethos. They are Independent Practitioner Association (IPA) focused PHOs and the community focused non-profit PHOs on which the PHC Strategy was based (although there are a third group of primary care physicians that exist independently of PHO structures) (Crampton et al., 2005). IPA focused PHOs have a history as previous IPAs, with a fee-for-service funding structure and are owned and governed predominantly by doctors. These PHOs are comprised of private small to medium-sized GP for-profit business models, which because of their proprietary nature and private investment in plant and equipment (Royal New Zealand College of General Practitioners, 2005), construct a discursive understanding of health as one of business. Risk management practices of liability and profitability are produced, which in turn constrain the way health care is both understood and delivered in this model. It is the practices arising from IPA focused PHOs that form the basis of discussion in this chapter.

Brent Morrissey, secretary of Health Care Aotearoa[67], is critical of the IPA focused PHO approach to governance, seeing the needs of communities marginalised by a discourse that privileges medical ownership:

[67] Health Care Aotearoa is a network for not-for-profit, community controlled primary health care providers in Aotearoa New Zealand.

> The contrast between a community focused PHO and IPA focused PHO is a substantial one. If the IPA can be described as groups of privately owned and operated medical services where they are the owners and employers of all staff it is axiomatic that such structures will reflect the legitimate values and priorities of GPs. They will not, however, succeed in addressing the needs for participation within communities they serve, most particularly within the Access PHOs.
>
> Thinking about PHOs as IPAs by another name is a flawed approach which is confrontational both to the expectations of the policy and the community of interest around primary healthcare. It will also ultimately be found wanting commercially when faced by crown audit wishing to see its significantly increased investment delivering on its policy aspirations.
> …
> To community and ancillary providers currently sidelined in the development process a growing sense of frustration is leading many to question whether they will ever be able to participate. If we can use the analogy of a shotgun wedding – which is how many GPs have interpreted this process – the community bride can in many cases be seen standing expectantly at the altar while the groom continues to fidget nervously in the men's room (Morrissey, 2003).

The writer is at pains to respect the 'legitimate values and priorities of GPs' but he is nonetheless forthright about the consequences of the IPA-PHO 'flawed approach' of generating profit. Although he does not use the term, the conflict of these business-focused values are self-evident ('axiomatic'), but more importantly, hostile ('confrontational') to both the intent of the PHC Strategy and the 'community of interest'. It is through practices of liability and profitability that power is exercised as resistance to the new order of PHC as GPs exercise their own agency by continuing to practise mostly curative medicine and struggle to embrace the social agenda the Crown expects as a return on its 'increased investment'. In so saying, not only is health represented in terms of profitability within a small business model, but also by the Crown whose interest is to reduce secondary care costs and at the same time, secure a healthy workforce.

Foucault's concept of governmentality can be applied here to illuminate the strategic power games (Lemke, 2000) played between the Crown (the state) and general practitioners over which entity has agency in governance: the Crown, the business proprietors, or the community. The Crown has written the 'rules' of the game in the PHC Strategy to purposefully empower the consumer 'community of interest' with participation in the governance structures of PHOs, but GPs are wary of losing financial control of their businesses to those who may have non-commercial interests. Consequently, the community consumer voice is marginalised and silenced in IPA focused PHOs, along with the health practitioners who are other than business owners and physicians (Cumming et al., 2005). The material effect of medical resistance to the new government discourse of PHC is these groups are positioned nominally in governance and secondary to the fiscal goals of the organisation.

Morrissey (above) portrays the position of these players in an analogy to a shotgun wedding, which commonly refers to a hasty and often coerced marriage due to unplanned pregnancy. The 'community bride' of consumers and 'ancillary providers' are pregnant with expectation over the promises contained in the PHC Strategy, while the Crown, posing as father of the bride, holds the shotgun of audit at the grooms' head. Meanwhile, the groom is committed to making good on his promises (contractual obligations), but is hesitant perhaps with regret, perhaps over contemplation of future lost liberties and autonomy.

That Morrissey (2003) chooses to use a gendered analogy reinforces the male persona of the real power brokers in health care; the Crown and medicine. Both entities paternalistically determine the fate of a female construction of consumers and ancillary providers, positioning them yet again, in an ongoing dependent relationship to medicine. As long as the business model of health care prevails, nothing changes for nurses or consumers.

Whether agency in health care lies with the Crown or with medicine, a senior politician interviewed for the study suggested control of money and decision-making are necessary for the successful governance of health services:

> *Only two things that matter in health and that's money and decision-making power. If you don't have either of those you're just wasting your time, which is why PHOs have a challenge (Senior Politician[2], p. 6).*

In fact, having the money and decision-making power is central to the success of any business enterprise and these comments suggest the speaker draws on a business discourse that understands health care, under whatever pretext, as simply a business. The construction of health within a business model is a product of neoliberal ideology which views health as just one of a number of economic goods which are subject to market forces (Stephens, 1987). Nurses working as employees in such a practice environment are positioned as a labour resource deployed in the interests of the business. The following section discusses this anachronistic employment model that curtails the autonomy of nurses and conflicts with the intent of the PHC Strategy (Carryer, 2005a).

Constraining nursing practice

Within the GP practice environment, the secondary relationship of nurses to doctors is compounded by the vicarious liability GPs have as direct employers of practice nurses. Liability as an employer is often equated with liability for professional nursing practice and stems from more traditional views of the doctor-nurse relationship. Expansion of nursing services is consequently seen as an escalation of medical liability, although under New Zealand law this is not the case (Carryer & Boyd, 2003). A discourse of ownership has maintained a misunderstanding of liability and positioned practice nurses to be dependent upon GP employers to 'allow' new nursing services to develop.

The following text was written by a practice nurse and published in *New Zealand Doctor,* a fortnightly publication circulated widely to a GP readership and chosen because it demonstrates the readiness of nursing to advance and the struggle to break the established order of medical ownership and control of health in the primary sector:

> The dichotomy of GPs using a private business model to provide a population health service has been no more pronounced than now, as practice nurses become more skilled and advanced nurse practitioners in

> general practice begin to explore expanded nursing service opportunities under the PHO framework. GPs will be understandably reluctant to relinquish control of nursing services while the risk remains with them. Practice nurses will be unable to provide the innovative and expanded nursing services described by the PHC Strategy while the constraints of private business employers remain to limit their opportunities.
>
> The current funding model restricts the nursing service practice nurses can deliver by placing the ownership of the nursing services with the GP owner/employer. The risks of the private business model encourages the GP to manipulate nursing services to fit within the financial constraints of the business, often ignoring the advantages that may be found in a more holistic model of nursing service delivery (Minto, 2004).

The writer draws on a PHC discourse in this portion of text and identifies the co-existence of two opposed models of primary health care provision, which are described as a 'dichotomy'. They are the duality of private business (with an emphasis on *personal* health) and *population* health services, and can be represented as a hierarchical pairing that privileges the private business model over population health.

There are a number of possible explanations for why private business continues to be favoured by doctors: firstly, individual illness-events fit discursively within a biomedical curative approach to health care; additionally, each consultation commands a fee from the practice to the GP, translating capitation funding to fee-for-service (see Kumar, 2004[68]; Thornton, 2004), as well as a patient co-payment; secondly as mentioned, the PHC Strategy (2001b) raises an expectation of coordinated primary care and public health strategies, which Crampton et al. (2005) suggest is viewed as an "imposition" on practice by medical practitioners that is "likely to increase costs without increasing revenue" (p. 241); and thirdly, public health education is a post-graduate specialty area and not the focus of

[68] Capitation money is distributed to individual GPs and into the practice account at a ratio of 74:26. Seventy-four per cent goes to the GPs and 26 per cent into the practice account (Kumar, 2004).

undergraduate medical education, leaving many GPs potentially educationally ill-prepared. However, the philosophical congruence of primary health care principles and models of care with the undergraduate educational preparation of nurses (Carryer et al., 1999), presents new opportunities for the expansion of nursing practice and for roles such as the nurse practitioner.

Allowing nurses to expand into provision of population health services will, as Minto points out, require doctors to 'relinquish control of nursing services' yet she says, the 'risk' remains with the business proprietor. The exact nature of the risk is not specified in the text as financial (although that is the implication), but could equally be the danger of a nursing service that is no longer under the gaze and direct control of medicine. Thus primary health care (as understood in the PHC Strategy 2001 document) is persistently represented as primary *medical* care within a business model, effectively marginalising community development and health promotion (Carryer et al., 1999), as well as nursing initiatives in these areas.

The continued privilege of the small-scale proprietary business model over public health services renders the concept of primary health care meaningless. Preventative interventions such as immunisation, breast and cervical screening, smoking cessation, disease detection and follow-up do command a direct government subsidy to the practice, but represent primary health care in extremely narrowly defined terms and ignores the need to educate for wellness (North, 1991). Rather than being viewed as dichotomous models, the personal approach and population health approach to health care are mutual requisites to comprehensive primary health care. Practice nurses who extend into broader practice areas and head towards nurse practitioner endorsement appear as an economic threat (Fountain, 1999, 2001; Meylan, 2004), as well as a territorial threat. Furthermore, nurses who exercise autonomy are perceived as a threat to the authority of doctors to direct the practice of their employees. It is this context that nurses interested in expanding their practice must negotiate.

With regard to governmentality, the state has re-categorised primary care to conform to an international and expert discourse of primary *health* care, including

community governance. There is a corresponding expectation that the rationality of research evidence and a government agenda will automatically lead to nurses and doctors adopting matching practices and attitudes (Winch, Creedy, & Chaboyer, 2002). Particular groups within nursing have readily drawn on a primary health care discourse, seeing opportunities for nurses to reduce health inequalities and to position nurses in advanced practice roles (Primary Health Care Nursing Expert Advisory Group, 2003). By adopting the PHC ideology of the state, the nursing profession is in a favourable situation (Larson, 1977) but that in no way indicates an uncomplicated position of superiority. As Foucault suggests, "there is not, on the one side, a discourse of power and opposite it, another discourse that runs counter to it" (Foucault, 1990, p. 101), rather there are multiple positions from which individuals contend. For example, PHC nurses are not a homogenous group and the PHC Expert Advisory Group identified the "need for a substantial culture change within nursing in order for it to align with the [PHC] Strategy and emerging PHOs" (2003, p. 5).

Neither primary health care nurses, nor nurses in general, are a homogenous group and there are diverse views on the appropriation of specific 'medical' tools into nursing discourse. An example of the diversity of opinion amongst nurses is in the following letter written to the editor of *Kai Tiaki*. The writer is a registered nurse with a Bachelor of Nursing and his letter constructs prescribing nurse practitioners as 'other' to nursing, aligned to medicine.

> As far as I am aware, there is already a group of health professionals diagnosing and prescribing medication: doctors. Why do we need another profession taking over a role, which, to me, is one of the fundamental differences between nursing and practising medicine?
>
> …
>
> What is the real need for nurses prescribing? Is it really that we want to help people access health care? Or are some nurses driven by a deep envy of doctors, wanting to be just like them, or as close as they can? I am proud to be a nurse, and see no reason to take on a role done by another profession for centuries. There are many things nurses do that doctors will never be able to do (Garth Edwards, 2005, p. 3).

The writer is clear in his assertion that diagnosing and prescribing differentiates the practice of medicine from nursing, describing them as 'one of the fundamental differences between nursing and practising medicine'. Demarcating jurisdictional boundaries, as he has, powerfully maintains the exclusivity between the professional groups (Abbott, 1988), highlighting the identity of each by the exclusion of and difference from others.

Using Foucault's understanding of dividing practices, the writer, having divided nursing off from medicine then moves to divide nursing also. He positions as 'other' prescribing nurses (nurse practitioners) from his normative non-prescribing position – a dividing technique that serves to distance one group of nurses from another and permits a critique of their non-normative otherness. Objectivising these other nurses, it is then possible to question their motivations of helping 'people access health care' and malign them with accusations of doctor 'envy' and an underlying self-interest of 'wanting to be just like them'.

Maintaining his own proud nursing tradition, the writer aligns himself with a century old medical perspective located in a 1904 Hospital journal: "There is nothing to justify a nurse in going beyond her limit and diagnosing and treating patients ... Her training ought to teach her above all things to keep within her own province" (cited in Gamarnikow, 1978, p. 107). Thus the writer (Edwards), is loyal to the (sexual) demarcation of knowledge ownership that establishes the rules concerning who has access to particular knowledges and who does not. Visible in this text, is the perception of a self-interested pursuit of power by a small number of elite nurses who have accessed these particular knowledges and who are now, as a consequence, at risk of disaffection by their own profession.

Resistance to an advanced nursing practice role was also acknowledged as coming from both nurses and doctors by a study participant from the Ministry of Health:

> *There's been resistance from nurses, resistance from medicine, definitely. Resistance to a system which pushes flexibility and innovation but doesn't know what it looks like and is not really willing to change that much … a little bit risk averse … Everybody's got multiple hats, there's conflict of interest everywhere (MOH, p. 6).*

This interview text highlights the cynicism of both nurses and physicians to 'a system' of political power that is "not so much imposing constraints" on health professionals as facilitating them towards "a kind of regulated freedom" (Rose & Miller, 1992, p. 174). The speaker seems frustrated by the hope that nurses and physicians could find creative improvements for primary health care services, but they seem unwilling and unable to envision a system beyond what already exists. Some change is acknowledged, but risk-management practices block 'flexibility and innovation' where they conflict with the discursive practices of business and clinical ownership. The consequences of a discourse of ownership are of vested interests in maintaining the status quo that protect money and decision-making power. Future possibilities are censored to preclude non-conventional care delivery models that might involve an expanded role for nurses and could potentially challenge medicine's monopoly position in the marketplace of primary health care services in New Zealand.

The constraints the business model of health has imposed on nursing practice center around medical dominance of the practice team. Nurses seeking practice autonomy are said to disrupt effective teamwork as physicians grapple with how to contain a simultaneous construction of autonomous and collaborative nursing practice. Both medicine and nursing have used professional collaboration for different ends and these issues are examined next.

Declaring independence

Acknowledging that health care cannot be delivered by one discipline alone, collaborative practice within teams of health professionals is becoming increasingly ubiquitous (Opie, 1999). The Nursing Council scope of practice descriptions for registered nurses and nurse practitioners positions nurses as both independent and collaborative practitioners, but makes no statement that collaboration must occur, or, that it must occur with medical practitioners. However, nurses are keen advocates for working collaboratively with physicians and view dialogue as the key to improved patient outcomes, to enhanced doctor-nurse collegiality and as an opportunity to share in one another's expertise (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; P. Hall, 2005; Marion Jones, 2002). As Opie (1999, p. 184) points out, this ideal and

egalitarian representation "writes 'the team' as an unproblematic site" and a more qualified representation suggests it as a site of "disciplinary power and knowledge claims … engaged in the protection of professional turf". On the face of it, medical groups endorse an egalitarian approach, but have an additional agenda of maintaining the medical governance role in health care provision through the disciplinary practices of surveillance. This is affirmed in the many cautions from medical representatives who call for nurses to work collaboratively rather than independently. For example:

> NZMA chair John Adams says doctors look forward to working collaboratively with nurse practitioners but have concerns about nurses working independently. Those concerns stem from the belief nurses and others are not, and will not be, trained to make diagnosis and treat as doctors are, he says (Sheddan, 2001).

Both nursing and medical practitioners have legally sanctioned autonomous practice in New Zealand (M. E. Burgess, 2002), but physicians have assumed medico-legal liability over nursing practice for reasons that are both historical and gendered (Carryer & Boyd, 2003). Willis (1989) notes control over medicine's own work has sustained medical dominance, legitimating its claim to professionalism and ideological autonomy. Furthermore, controlling and taking responsibility for the work of others in health care is seen as a legitimate task for the medical 'experts' (Willis, 1989). From a medical perspective, it then follows that if autonomy is what defines a profession, nursing cannot be a profession given its apparent subjection to medical control. The following texts illustrate how the notion of nurse practitioner autonomy and independence is inconceivable within a medical discourse, irrespective of the legality of the Nursing Council scopes description under the HPCA Act, 2003.

The first text from *NZ Doctor* is from an article entitled 'Nurse practitioners say no to oversight' and reports a portion of Professor Jenny Carryer's address to the 'Introducing Nurse Practitioners' conference in Wellington, in September 2001. The second text is an excerpt of an interview with a representative from the College of Nurses Aotearoa, where the interviewee describes an email exchange between herself and an Association of Salaried Medical Specialists (ASMS) office

holder. The third text is also from *NZ Doctor,* in an article entitled 'Independent nurse moniker dropped' and reports a portion of NZMA GP Council Chairman, Dr Peter Foley's comments about the announcement of Cabinet's approval of prescribing rights for nurse practitioners.

1. Nurse practitioners will collaborate with other health professionals but will not accept oversight from medical practitioners…they will collaborate in terms of discussion and collegiality with medical practitioners. However, they will not accept legislative or doctor oversight (St John, 2001).

2. *Because he and I have engaged in an exchange in which he has said, "ASMS is not opposed to nurse practitioners but we are opposed to independent nurse practice." I e-mailed him back and said, "Could you explain to me how that works?" And he e-mailed me back something about it's about autonomy. So I said to him, "What is your understanding of autonomy?" And we're kind of stuck there at the moment (the College, p. 21).*

3. In the initial proposals, Dr Foley says, practitioners were described as 'independent', which was a concern to GPs. It has been deleted from the final description and signals a move to a more integrated system, he says. "I have always said they should be in communication with other health professionals as anyone prescribing needs to make diagnoses, so it is good to see they have made it clear," Dr Foley says (Rillstone, 2005).

The first excerpt of text reports Professor Carryer's statement that nurse practitioners will collaborate with, but not be subject to, oversight from medical practitioners and is a statement that could equally be said of all registered nurse practice (Ministry of Health, 2002). Essentially, this article is a 'no-news' article when already RNs practice legally without medical oversight. It follows, therefore, that the most experienced and expert nurses who are endorsed as NPs will practice without medical oversight also. However, the headline 'Nurse practitioners say no to oversight' discursively positions NPs as dissenters who are declaring their independence from doctors. Although stated clearly that nurse practitioners will collaborate and discuss with medical practitioners in a collegial

manner, the headline has been chosen to highlight the refusal of nurse leaders to concede sovereignty to the oversight of medicine and seems to suggest NPs will be acting alone. The GP audience, for which the article is intended, may well be alarmed by such a declaration, as many believe they are responsible for nursing practice and would assume to be responsible for NP practice also. Given this article was printed in the same issue that carried an editorial about nurse practitioners entitled 'Another kick in the guts' (Fountain, 2001), this edition of *NZ Doctor* positions the new NP role as an adversary to medical sovereignty in health care.

The interview excerpt (2) identifies not highly skilled nurses to be the crux of the problem but their *independence* and *autonomy* from medicine. An exploration of the meaning of autonomy between the correspondents was pending at the time of the interview, but in the interim, the text is suggestive of an inconsistent shared understanding of the term. Nurses understand practice autonomy as being free from the *requirement* for physician collaboration or supervision (Pearson, 2004), whereas physicians use collaboration as a discursive practice to oversee and, therefore, control nursing decision-making. The discourse that preserves medical sovereignty makes it virtually impossible to conceive of a possibility for nurse practitioner independence (Foucault, 1981). To accept nurses as autonomous is to reject the division between doctors and nurses and to acknowledge them as professional equals; for it is the physicians' autonomy that is prized so highly and it is a prize that will not be so willingly shared. In consequence, the technique of power that rejects the notion of nurse practitioner (and nurse) autonomy, serves to reassert the traditional hierarchical relationship of non-reciprocal surveillance of doctors over nurses.

'Independent' appears in the headline of the third text and is identified as the 'concerning' moniker (or name) deleted from the nurse practitioner prescribing role. The inference in the text is that if 'independent' were left in the documentation, nurse practitioners would not be in 'communication with other health professionals' or part of a 'more integrated system'. Somehow the action to delete the troublesome word restores nurses to their rightful place – a place of dependence on medicine for patient diagnosis, at least. Dr Foley does accept the

reality that nurse practitioners will prescribe, for now legal provision has been made (Medicines (Designated prescriber: Nurse practitioners) regulations, 2005), but he subtly reasserts the key difference between medicine and nursing is the dependence of nursing on medical diagnoses. This serves, as Foucault (1983b) suggests, to put into operation a system of differentiations that incur a relationship of power, despite there being no legal basis for it.

The notion of independent and autonomous nursing practice has been contentious for medicine and the shift in state funding practices in relation to the provision of midwifery services served to augment physician sensitivity to nurse practitioner independence. The precedent set by midwifery is highlighted briefly in the following section because their independence presaged the introduction of the nurse practitioner role and forewarned general practitioners, in particular, to potential business losses.

The midwifery precedent

Factors serving to increase the perception of nurse practitioner threat to GP services are the general willingness for nurses to work in areas with traditionally under-served populations, such as rural areas and low socio-economic areas (Rasch & Frauman, 1996), as well as historical factors relating to the development of independent midwifery in New Zealand. The Nurses Amendment Act, 1990 re-established midwives as autonomous practitioners, who no longer required medical over-sight of their practice, or for provision of prescriptions. The amendment allowed registered midwives to claim maternity benefits, pharmaceutical benefits, benefits related to buildings and equipment, claim refunds normally claimed by medical practitioners, to be involved in fee setting, to prescribe medicines including pethidine and to admit women to maternity wards on the same terms as medical practitioners (Helen Clark in New Zealand Parliamentary Debates, 1990, August 21). As Stodart (1990, p. 21) noted at the time, "[t]he act has enormous consequences for nursing in that the autonomy and rights won by midwives set a precedent for the nursing profession to seek them as well".

The move saw the medical share of maternity services (or market share) drop dramatically from one hundred percent in 1990 to thirty-seven percent in 1997 (Guilliland, 1998). Midwifery's market takeover deprived many GP obstetricians of maternity-associated revenue as well as a pleasurable aspect of their practice and has led to an understandable determination that the mistake of failing to contest midwifery independence would not be repeated with nurse practitioners.

Each participant interviewed for the study mentioned the precedent set by midwifery as a key factor in the resistance by physicians to the introduction of the nurse practitioner role. The following interview excerpt refers to the personal frustration this nurse representative felt as recollection of past events relating to midwifery hindered the progression of talks concerning nurse practitioners:

> *…virtually every time I sat around the table in Wellington in a multi-disciplinary group talking about nurse practitioners, the statement was always made, "Well look what happened with the midwives, we're not going there again". I've heard it a hundred times (the College, p. 15).*

The speaker in this narrative labours the frequency with which she encountered this barrier to discussion by emphasising the experience was not a casual occurrence, with the phrases 'virtually *every* time', 'the statement was *always* made' and 'I've heard it *a hundred* times'. She is unwillingly and deliberately discursively positioned alongside midwifery in this text by virtue of her related profession: nursing; and consequently, excluded on the basis of the association, with speaking rights revoked. She is effectively banished, for the moment, from her legitimate position as spokesperson for nursing (Davies & Harré, 1991; Winslade, 2005). Other members of the multi-disciplinary team are positioned more powerfully with the *a priori* and paternalistic right to decide on an outcome for nurse practitioners ('we're not going there again'). Power relations are thus brought into being with the recollection of a past event that had undesirable (financial) consequences for medicine, at least, and reproduces the nurse practitioner role within the same competitive discourse as midwives. Nurse practitioners are seen as competitors for patient services currently occupied by medicine and further discussion that would enhance independence for nurses, in

similar ways to midwifery, are prohibited by a discourse that privileges medical ownership.

Independence for midwives would have been considerably curtailed had the Health Select Committee, at the time, not recognised that prescribing privileges were a key to independence from general practitioners. Provisions to prescribe were added to the original Bill by the committee and went through the second and third readings in very short time, with opposition party support and medical comment, but not significant resistance (New Zealand Parliamentary Debates, 1990, August 21). The Nurses Amendment Act amended five other Acts and a number of regulations and provided midwives with the capacity to:

> prescribe most drugs or medicines that are available, but it is incumbent on them to constrain themselves from prescribing those drugs with which they may not have a high level of familiarity or that are not related to the process of childbirth (Don McKinnon in New Zealand Parliamentary Debates, 1990, August 21).

The legislation invested a high level of professional accountability in midwives, particularly as the education level of preparation was an undergraduate degree[69]. However, when the proposal for nurse practitioner prescribing was put forward with the educational preparation situated within a clinical masterate, there was protest both in and out of nursing. The NZNO had reservations about the accessibility of such a high level of preparation for the majority of nurses (Gunn, 1999) and the medical groups pronounced independent nurse prescribing to be unsafe without a medical degree (J. Adams, 2002, August 15; Boswell, 2005a; Chan, 2001; "Concern over new nurse job," 2001; Fountain, 1999; Maling, 2000; Mackay, 2003; Moller & Begg, 2005; NZMA, 1999; NZ Medical Council, 1999; Pegasus Medical Group, 1999; Royal New Zealand College of General Practitioners [RNZCGP] 1999; Simon, 1997). The precedent established by midwifery independence became the basis for medical resistance to the notion of a *most* expert nurse who could *prescribe*.

[69] Pharmacology curriculum for midwives includes the antenatal, intrapartum and postnatal period of up to six weeks.

Health and Disability Commissioner, Ron Paterson, wisely questions the notion that any practitioner – nurse, doctor or midwife – should be independent. Although discussing the safety of maternity services in New Zealand, his comments apply to all health sector areas. He says: "I think we need to question this whole idea of an 'independent' practitioner. I don't think anybody should be fully independent in the health system. Everybody needs to work in teams and to work collaboratively" (in K. Brown, 2006, 25:24 - 25:34).

Summary

As a technique of government the new regime of primary health care challenged existing medical *business* practices and created greater possibilities for nurses to expand into advanced practice roles. The PHC Strategy has been variously subverted by the translation of capitation funding into traditional fee-for-service revenue collection, as general practitioners continue to view their services within a business model. PHO governance mechanisms have remained with general practitioner owners, rather than being shared with a range of stakeholders, including consumers. In less competitive environments where ownership of patients and funding streams by medicine are no longer seen as territory to be protected, opportunities for nurses wishing to extend into advanced practice roles appear to be less constrained. These opportunities are examined further in chapter ten.

The shift in state funding practices in relation to the provision of midwifery services served to augment physician sensitivity to nurse practitioner independence. The precedent set by midwifery presaged the introduction of the nurse practitioner role and forewarned general practitioners, in particular, to potential business losses. The notion, therefore, of independent and autonomous nursing practice has been contentious for medical groups, who ostensibly endorse an egalitarian approach to collaborative practice, but have an additional agenda of maintaining the medical governance role in health care provision through the disciplinary practices of surveillance. This has the additional benefit of curtailing a potential competitor in business.

At the time of writing, there are thirty nurse practitioners registered with the Nursing Council, twelve of whom are able to prescribe medications within their scope of practice (Cassie, 2007). Perhaps the threat of competition from nurse practitioners lies not to the bottom line, but to the prestige and dominance of physicians prepared only to bachelor level when increasing numbers of nurses are masters and PhD prepared. While highly skilled nurses appear to be a welcome addition to the workforce, the notion of a *most* expert nurse who could prescribe, is particularly inflammatory and this is examined further in chapter nine.

Chapter 9: Prescriptive Privileges

Introduction

The announcement of an amendment to the Medicines Act, 1981, made during the work of the Ministerial Taskforce on Nursing in 1998, would enable nurses to prescribe in two government priority areas, child and family health and aged care only (Medicines Amendment Act, 1999; and associated regulations, Medicines (Designated Prescriber: Nurses Practising in Aged Care and Child Family Health) Regulations, 2001)[70]. A New Prescribers Advisory Committee (NPAC) was subsequently established under section 8 of the Medicines Act, 1981, to provide advice to the Minister of Health regarding proposals from new groups of health professionals seeking prescribing rights. Approval for nurses to prescribe in areas other than child and family health and aged care must be sought from this committee, who would then make a recommendation to the Minister. This process was slow and arduous and required individual schedules of medicines for each set of designated prescriber regulations, as well as regular schedule updates via amendment to the regulations. As lists become outdated, best practice was impeded (Ministry of Health, 2004). The intention for some time has been to replace the Medicines Act, 1981 and Medicines Regulations, 1984 with the Therapeutic Products and Medicines Bill, 2006, now scheduled for enactment in late 2007. The omnibus bill is in two parts: firstly it introduces a joint regulatory scheme for both Australia and New Zealand; and secondly, addresses the scheduling of medicines and prescribing rights. Until such time as the Bill is passed, the provisions of the existing legislation remain.

More than seven years after the announcement that would provide for nurse prescribing, the outgoing Cabinet in September 2005, approved the necessary amendment to the Medicines Regulations, 1984 to allow nurse practitioners to prescribe beyond child and family health and aged care, in his or her nominated area of practice (Medicines (Designated Prescriber: Nurse Practitioners) Regulations, 2005; Misuse of Drugs Amendment Regulations, 2005). The

[70] Paula Renouf was the only nurse practitioner in New Zealand to have prescribing rights under these regulations.

intervening years were characterised by the efforts of the Nursing Council to work with the Ministry of Health to progress the nurse prescribing regulatory framework. Whereas chapter eight examined the PHC Strategy and its challenge to the *business* practices of general practitioner proprietorship, this chapter examines the introduction of prescribing for nurses, appropriating the *clinical* practices of physicians in general, but particularly those of general practitioners. Foucauldian notions of governmentality are used throughout the chapter to illuminate various positions established by a medical discourse, as well as the shift in existing forms of power as nursing began to engage productively in its own governance, creating a new space for nursing autonomy and independence from medicine.

Stealing the master's tools

The Taskforce Report (1998) brought to the foreground the discursive shift of advanced nursing practice that had been occurring within nursing during the 1990s. It formally introduced into general nursing discourse practices of assessment, diagnosis and the prescription of treatment as fundamental to registered nurse practice, albeit at an advanced level. Foucault (1991c, p. 59) writes of "the limits and forms of the *sayable*" suggesting it is only possible to speak of particular discursive practices within particular domains. Medicine has appropriated and institutionalised these practices by propagating a regime of truth emerging from a medical discourse that pronounces diagnosis and prescribing as possessions of medicine and can, therefore, be delivered safely only within a medical degree. Nursing, on the other hand, has propagated an alternate regime of truth that draws on a body of academic research to suggest these medical possessions can be made available within a nursing discourse. In so doing, interdisciplinary boundaries are crossed, redrawing the limits of possibility for nursing.

In the following interview excerpt the development of prescribing and diagnosis for nurse practitioners is referred to as "*stealing the master's tools"*. The participant goes on to say, *"And we've crossed that last frontier of diagnosis which medicine has always regarded as sacrosanct. It's how they hold, maintain and control the entire world by owning diagnosis" (the College, p. 8).*

This participant appears to be drawing on the words of the Black-American feminist poet and writer, Audre Lorde and her famous line, "for the master's tools will never dismantle the master's house" (Lorde, 1984, p. 112). By choosing to use it, the speaker in the text is deliberately but facetiously positioning nursing as having been enslaved to the gendered male 'master' of medicine; however, *stealing* the tools repositions nursing not as thieving servants, but as active agents. In Marxist terms, this was no opportunistic theft but an astute challenge to the master's wealth by 'acquiring' his means of production of wealth.

Within a neoliberal discourse, where health care is viewed as a commodity, diagnostic and prescribing practices are related to business profitability as core clinical functions and are the skills that have defined medical practice (Fairman, 2003). However, within nursing discourse, these skills represent a fragment of the whole of nursing practice (Carryer, 2002; Deborah Harris in Cassie, 2005b).

The resistance of medicine to sharing prescribing rights with non-physicians was largely based on the presumption that only physicians could diagnose. Maintaining diagnosis as 'sacrosanct' to medicine not only preserves its monopoly over health care, but also bars others from prescribing both treatment and medications. Positioning diagnostic practices as sacrosanct, the speaker from the College (above) casts physicians in the role of priest, empowered with a clinical gaze that can divine deviant pathology (Foucault, 1994). Understandings of priests as male, constructs membership of the diagnostician group as gendered, creating a sexual division between those entitled to diagnose and those who may not. Thus a discourse of ownership of diagnosis serves to differentiate medicine from nursing, contributing to an overall objective of the primacy of medical competence and know-how (Foucault, 1983b).

Returning to Audre Lorde (1984), her point, when applied in this context, is that nurse practitioners owning a share of the master's tools of diagnosis and prescribing "will never dismantle the master's house" (p.112); but then the demise of medicine has never been the intention of nursing. The access of nurse practitioners to these tools may challenge the monopoly medicine has held over health care delivery, but using them in the same way medicine has used them

simply reproduces the tyranny, via another means. The nurse practitioner role was introduced in New Zealand to enhance access for population groups who were underserved by existing health services provided by medicine and nursing alike. To re-create a nursing version of medicine, will as Lorde stresses, "never enable us to bring about genuine change" (p.112). Rather, it is the role's *difference* from medicine that is its strength (Lorde, 1984). The articulation of those differences remains a challenging task and nurse practitioners are regularly described as mini-doctors or doctor substitutes, reflecting an understanding of health care as a domain only physicians can fill completely (Mundinger, 2002).

The supervision concept

Many physicians would argue they are not opposed to nurses prescribing, but take exception to the suggestion that nurses or nurse practitioners would prescribe, or indeed, practice independently, without medical supervision. For example, an American Medical Association position statement, published in the 1970s, supported an expanded role for nurses, including improved education and career ladders and involvement of nurses in collaborative practice models (American Medical Association Committee on Nursing, 1970). The caveats throughout the position statement, however, are phrases such as: "under the supervision of the physician" (p. 1881); "all aspects of patient care should be under the direction and supervision of a licensed physician" (p. 1882); and "the physician, as the logical leader having definitive legal authority in matters of medical care, must accept this ultimate accountability to the patient" (p. 1883). Nurse practitioners were a recent and new phenomenon in the United States at that time (Ford, 1997), but this position appears to be characteristic of the preference of many physicians in New Zealand some thirty to thirty-five years later, as the following section shows. The notion of nurse practitioner autonomy is rejected and medically supervised teamwork is insisted upon.

Following a Ministry of Health initiated round of consultation, on June 15, 2005, the Nursing Council submitted a proposal document to the New Prescribers Advisory Committee on the implementation of nurse practitioner prescribing that collated submissions from an earlier consultation round in April (NZ Nursing Council, 2005, April; Ministry of Health, 2005, July). Before NPACs decision on

the proposal was made, Chair of the NZMA, Ross Boswell, delivered a speech on June 17, to GP delegates attending a CME conference in Taupo, during a session entitled 'medico-political'. An excerpt follows:

> The NZMA has had long-standing concerns about proposals to allow autonomous nurse prescribing, which we have expressed over a number of years. This proposal seems looney, and our response to it was hard-hitting. We pointed out that a medical graduate, having completed a six-year university course, is not permitted to prescribe without supervision during her intern year. We cannot see that a nurse, after completion of a two-year Masters course, can be so much better qualified that he or she should be unleashed directly on an unsuspecting public. We described the proposal as putting at risk the health and safety of New Zealanders. We proposed that instead, nurses with such a level of qualification should not prescribe independently, but should work under standing orders and the supervision of a medical practitioner (Boswell, 2005a, p. 8).

The position of the speaker in the text is strengthened by multiple uses of inclusive pronouns, which appear in all six sentences in the paragraph ('we' and 'our'). The pronouns serve to emphasise the views expressed belong not only to the speaker, but also to the NZMA and its membership, comprised of all disciplines within the medical profession, including specialists, GPs and medical students. The 'proposals' referred to are for more stream-lined nurse practitioner prescribing regulations contained in the Nursing Council submission to NPAC, two days earlier. The speaker refers to 'long-standing' and 'hard-hitting' responses, by which he likely refers to the NZMAs submission to the Health Select Committee on the Medicines Act Amendment in 1999 (see New Zealand Medical Association, 1999), various editorials and media releases (J. Adams, 2002, August 15), consultation round submissions and the lobbying of Ministry officials, described later.

Said (1983) raises the issue of intentionality by the author of a text, questioning if an author is deliberate or unthinking in his/her choice of words. Given the constitutive nature of discourse, the material effect of language use is the construction – intended or otherwise – of the object of which it speaks. The text

above does not contain casual remarks made in the course of everyday life, but a prepared speech delivered by an "expert" in what can be termed a "serious speech act" (Dreyfus & Rabinow, 1983, p. xxiv). The fact the speaker chooses to use the colloquial term for lunacy, 'loony', constructs the proposal for nurse practitioner prescribing as deranged and possibly dangerous. Thus positioned, the "mad[wo]man" is dismissed, according to Foucault, his/her word "considered null and void, having neither truth nor importance…" (1981, p. 53). The medical diagnosis of nurse prescribing as insane suggests the traditional medical solution applied to the insane would logically apply here also; the practice of containment.

Castel (1991, p. 283) explores the imputations of dangerousness in the insane and suggests the classical medical response is to opt "for the all-out prudence of interventionism". That is, it is better to act to prevent a proposal that might turn out to be dangerous, than abstain and have it materialise. Here the 'risk' to financial viability is not for the first time couched as risk to 'the health and safety of New Zealanders'. Nurse practitioners present a viable alternative to the established order, but could not be considered a significant threat without prescribing rights. On the other hand, with prescribing rights, nurse practitioners are an attractive provider of services to both consumer and funder alike.

By presenting physician prescribing as the norm, nurse prescribing is positioned as a deviation from the norm. More than a mere aberration, the deviation is constructed as insane. In Foucauldian terms (2002), the practice of dividing the sane from the insane is a power technique for controlling that which is not 'normal', a move rationalised by the desire of medicine to protect an 'unsuspecting public' from 'loony' nurses. While the speaker is careful to name the proposal as loony, the proposal was designed in consultation with nurses, by a nursing body, on behalf of nurses, and thereby positions nursing as irrational. Thus the need for medicine to contain and control this problem is made synonymous with patient safety.

By raising the issue of patient safety, a fallacy of bifurcation is presented to the audience that assumes there are only two possible prescribing alternatives; safe medical prescribing and unsafe nurse prescribing. In fact there are more than two

possible alternatives such as, nurse practitioners will make safe prescribing decisions, physicians sometimes make prescribing errors and nurse practitioners will sometimes make prescribing errors. Where practice falls below the required standard of competence, practitioners – be they nurse or doctor – are referred to the appropriate professional conduct committee (HPCA, 2003). Thus the same provisions are made in legislation for health practitioners in the unfortunate event that a prescribing error is made.

The know-how and competence of nurses to prescribe is called into question as the speaker differentiates between medical and nursing educational preparation for prescribing. The self-evident superior status and privilege of medicine is recalled in the institutionalised and apprentice-like tradition of undergraduate medical school training, compared to the preparation of nurse practitioners. Freidson (1970) suggests exclusively segregated professional schools declare a body of special knowledge and skill that cannot be obtained elsewhere and rules out legitimate arbiters who received their knowledge by another means. Absent from the speaker's comments, is any acknowledgement of the postgraduate years of specialty nursing practice experience (at least four) and prescribing practicum hours and supervision required of nurse practitioners (F. Hughes & Carryer, 2002), or the fact that medical students at Auckland University receive instruction alongside nurses. However, the issue revolves not around equivalency, perhaps, but around some secret knowledge mysteriously acquired by "the concentration of this knowledge in a privileged group" (Foucault, 1994, p. 55) during the asperity of medical internship.

Medical power is exercised in this text by the injunction to maintain the subordination of nursing to medicine by supervising nurses' prescribing practice. In Foucauldian terms, surveillance positions a nurse as an object, subject to the gaze and scrutiny of a doctor, but conversely, positions a doctor as all seeing and infallible. The superior power and integrity of doctors suggests the ability to offer "a juridical or moral guarantee" (Foucault, 2002, p. 257) by acting as reliable sponsors for nurses who prescribe. The idea of sponsorship is reflected in the twin themes evident in Foucault's notion of dividing practices, those of exclusion, but also a duty to the excluded (Dreyfus & Rabinow, 1983). Although there is no

legal requirement to supervise any aspect of nursing practice in New Zealand, it may be viewed by doctors as their moral responsibility to protect, not only the public, but also nurses from potential malpractice. Having excluded nurses from the possibility of prescribing with autonomy, the duty of medicine – under the guise of a recommendation – is to superintend nurses by virtue of their superior knowledge and experience.

This text is typical of the increasing desperation of physicians to stop the proposal for nurse practitioner prescribing from going ahead. The florid language of 'loony' was surprisingly ill-considered and Dr Boswell later chose to clarify his comments (Boswell, 2005b). A more convincing strategy may have been to use the same standard of evidence expected when making clinical decisions affecting patient safety (Paul Watson in Davis, 2005, July 23). The following section portrays a wider range of positions to the proposals for nurse practitioner prescribing. In addition to an official medical perspective, those of nursing, the state, the media and consumers are portrayed, including the means of power used to secure particular positions; those of medical hegemony, research and legislation, the market and also controversy.

Nurses push for prescription power

The title of this section takes its name from a television news item screened at the end of July 2005. Aside from being an alliterative device, the title, 'Nurses push for prescription power' positions nursing as wanting to secure a more powerful position than the traditional depiction of limited autonomy. At the same time, the title acknowledges the ability to prescribe as being a powerful discursive practice normally associated with the social prestige of medicine.

As mentioned, the Nursing Council had earlier released a consultation document to finalise the regulations for implementation of nurse practitioner prescribing (NZ Nursing Council, 2005, April) and this was followed by another Ministry initiated round of consultation. The attention attracted by Dr Boswell's 'loony' comments generated sufficient interest for the media to run a television news item on the national news and later in the same evening, a separate documentary

programme. The transcribed text of the television news item follows, including a description of the visual images used.

> **Newsreader:** Plans to give nurses more power to prescribe drugs are being fought tooth and nail by some doctors. They say the move could put patients' lives at risk. But experienced nurses say they're qualified for the work and the Health Minister agrees. *[Visual image: Newsreader Judy Bailey is seated in TV studio. Background image of registered nurse medal and some pills]*
>
> **Reporter**: Jenny Phillips has been a nurse for forty years, she is also a nurse practitioner with a two-year post-graduate master's degree, specialising in wound care. *[Visual image: Jenny Phillips driving a car down a suburban street. Gets out of car and approaches a patient's house with bag and clip board in tow]*
>
> **Patient** *(Eddie) greets Jenny at door of his house*: "Good morning Jenny, good to see you, come on in."
>
> **Jenny:** "OK, thanks."
>
> **Reporter:** She can order X-rays for patients like Eddie John, devise a treatment plan, but she can't prescribe pills for his leg ulcer. *[Visual image: Jenny attends to Eddie's small leg ulcer - changes the dressing using a dressing pack and wearing gloves]*
>
> **Jenny:** It's frustrating for me, but I think it's even more frustrating for the patient. *[Caption: Jenny Phillips, Nurse practitioner]*
>
> **Reporter:** Eddie has to see his Palmerston North GP each time he needs medication.
>
> **Eddie:** For Jenny to actually do that would be a wonder.
>
> **Reporter**: Nurse practitioners like Jenny have been around since 1998 but can only prescribe for children and the elderly. There are 130 nurse practitioners waiting for the green light for that scope to be widened to include all areas of nursing, something the health ministry is consulting interested parties on right now. *[Visual image: Another unnamed nurse is shown consulting with a patient in an office. She is shown handling medications, talking on the phone at a desk with BP cuff and stethoscope clearly visible]*
>
> But some doctor groups say it's unsafe.
> *[Visual image: Close-up of Dr Boswell looking at an x-ray image]*
>
> **Dr Ross Boswell:** We see it as a matter of safety; we see it is a matter of teamwork. We see it as a matter of having horses for courses; doctors doctor and nurses nurse. *[Caption: Dr Ross Boswell, NZ Medical*

Association. Visual image: Dressed in suit and tie. Hi tech environment in background - possibly ICU or a laboratory]

Dr Mark Bukofzer (Anaesthetist): We'd be very loath to see any new system introduced without rigorous and vigorous debate that may lessen that safety standard. *[Caption: Dr Mark Bukofzer, NZ Society of Anaesthetists. Visual image: dressed in theatre scrubs and hat. Background setting possibly theatre, suction equipment and IV stand visible]*

Reporter: The nurses' council argues nurses have prescribed safely in the United States for forty years. *[Visual image of Massey University Professor Jenny Carryer talking with Lorelei Mason in an office, discussing a report. Both dressed in smart street clothes]*

Jenny Carryer: We know from the evidence that nurse practitioners are very cautious and intelligent prescribers. *[Caption: Jenny Carryer, NZ Nursing Council – should be College of Nurses. Close up of Jenny with bookcase in background with prominent book title 'Biology' on shelf]*

Reporter: The health minister says the move will go ahead despite doctors concerns. *[Visual image of Annette King in her office carefully reading papers]*

Annette King: I think some of them are threatened, but they don't need to be. Nurses don't want to be doctors they want to be able to undertake a greater role within their training and their competency. *[Close up of Minister]*

Reporter: But it's shaping up as a battle. *[Visual image of gloved hands holding plastic forceps attending to a leg ulcer wound]*

Dr Ross Boswell: I don't think that it is a question of patch protection it's a question of safety. *[No caption, same setting as earlier]*

Jenny Carryer: And I'm surprised they don't look at the need out there and work with us to meet that need. *[No caption, same setting as earlier]*

Reporter: Submissions to fine-tune the regulations on wider nurse prescribing close in a month. Lorelei Mason, One news. *[Closing shot of Jenny Phillips putting the final touches on Eddie John's leg ulcer dressing*] (L. Mason, 2005, July 29).

Typical of media sensationalism, an adversarial note is introduced early in the news item by the reporter, with the use of a battle metaphor ('being fought tooth and nail') and locates this issue for viewers as a stereotypical 'battle' of the sexes. But it is more than a feminist matter and the text as a whole portrays both medical and nursing professions endeavouring to produce a 'will to truth' that will sway

popular opinion and have an impact on impending regulatory decisions and become the accepted discourse. According to Naughton (2005), reform is not inevitable on the basis of ideology alone, but rather, the idea must be "transformed into discourse" (p. 49) where it will gain validity, legitimacy and force. Not at all a neutral information medium, this news item is a tactic used by nursing and medical groups to elicit the general agreement of the population by building a case that gathers sufficient momentum to bring not only an accepted change, but one that is demanded (Naughton, 2005).

Medicine in general is differentiated from nursing by its traditions of authority on matters of life and death, of higher status and of being privileged by the regulations that have governed prescriptive authority in this country. There is a claim to truth in the news item text that medicine has the know-how and competence to prescribe safely, whereas nursing does not. This position is contested by a nursing discourse that draws on research and consumer support, as well as the wider health agenda of 'the need out there.'

Conveying a sense of medicine's objectivity, a counter-discursive technique denies this is an issue of 'patch protection', purporting concern for public safety. Medical opposition is mitigated with the softer phrase, 'a matter of safety,' disguising the baldness of a categorical statement that nurse prescribing will be *unsafe.* However, there is no mention of the economic well-being of physicians who stand to loose income if nurse practitioners can prescribe. The reporter alludes to this with the suggestion Eddie will no longer visit his GP for medication if the nurse practitioner visiting him can prescribe. It is unlikely that medical opposition based on an anti-competitive premise will win popular support, whereas 'lives at risk' does tend to arouse concern.

Both parties in the text (medicine and nursing) exercise power, not by force of personality, but the use of words that claim authority and the backing of each respective academy. Medicine draws on the set phrase 'horses for courses' (meaning what is suitable for one person or situation might be unsuitable for another) and the self-evident, or common sense 'truth' of this as an idiom. Medicine attempts to normalise this truth as rational, that to think otherwise

would be irrational. In Foucauldian terms, a dividing practice is employed by medicine to normalise the demarcation between doctors and nurses ('doctors doctor and nurses nurse'), making a clear exclusionary statement that prescribing is within the practice domain of physicians only. This would position nurse practitioners in an ongoing dependent relationship to medicine for prescriptive orders and undermine any competitive economic advantage their role could otherwise offer. Nursing more substantially, however, has the support of the Nursing Council and draws on selected research 'evidence', which according to Naughton (2005, p. 50), "is a vital component in the manufacture of legitimate authority" to bring about a desired change. The visual images used show Professor Carryer with the reporter referring to research evidence and coincidently, perhaps, on the office bookshelf, is a textbook prominently labeled 'Biology' and tends to remind viewers of the link between nursing and the sciences.

The Minister of Health, Annette King, takes a position of domination ('the move *will* go ahead despite doctors concerns') and in doing so, subordinates medicine to her will. She simply acknowledges the inevitable medical opposition and perceived threat to a shift in demarcation lines, but reinforces the difference between nurses and doctors. Not expressed directly, she points to the HPCA Act, 2003 ('a greater role within their training and competency') as the legally enabling framework for advanced nursing practice, indicating the power already institutionalised by the state for this role.

Both nursing and medical voices refer to teamwork, although in very different ways. The medical voice links safety of prescribing to teamwork in the same sentence, although the understanding of teamwork is not made clear here. Other public remarks this spokesperson has made concerning nurse practitioner prescribing suggests it should only occur under the "supervision of a medical practitioner" (Boswell, 2005a, p. 8). A tactic used by medicine is to maintain surveillance of nursing work under the guise of teamwork. By linking teamwork to safety, the speaker is suggesting nurse practitioners who prescribe medications would be unsafe without medical supervision. Professor Carryer, however,

reverses the customary understanding of nurses working with doctors by inviting medicine to engage in teamwork with nurses ('work with us').

The similarities between doctors and nurses are implied by the reporter with reference to a high level of education and the ability to order X-rays and plan treatment. These similarities are contradicted in the visual images, which highlight difference in the contrasting practice settings the nurse practitioner and doctors are portrayed in. There are images of a nurse practitioner visiting a patient in the low-tech environment of his own home, performing a relatively low-tech wound dressing procedure. These images are juxtaposed against images of doctors in the high-tech context of intensive care and theatre, examining X-rays. These gendered media representations reinforce traditional stereotypes and position the male doctors in useful and important technical environments and the woman-nurse in the home, presumably where she belongs. The diversity of practice setting serves also, to distance the doctors from the nurse practitioner, as does the judgment that nurses prescribing will put 'lives at risk'.

Referring to the second round of Ministry initiated consultation, concluding on August 26, information about the consultation process is provided in the text. Contrary to the implication that all nurses will be able to prescribe, some detail about the number of nurse practitioners prescriptive privileges are likely to affect, is included. The spokesperson for the Society of Anaesthetists implies this initiative is new and in need of extensive debate. Yet absent from the text is mention of the six year old Medicines Amendment Act 1999 that makes provision for designated prescribers and that stakeholders will have been consulted six times in total, over this proposal.

The use of the pronoun 'we' is used by the three doctors interviewed and refers to the body of membership and therefore authority each person represents. The two medical doctor's names are prefaced with the title 'Dr'; however, Jenny Carryer's title of doctor, or indeed professor, is omitted from the captions, but may simply have occurred to minimise any confusion between medical doctor and doctor of philosophy. The medical spokespeople use 'they', suggesting all doctors are opposed to the idea, yet absent from the entire text is the many individual doctors

who are supportive of nurse practitioner prescribing. The Minister of Health lends the authority of her office to the nurses' claim, as does the lengthy experience and post-graduate education of the nurse practitioner the news item showcases, in Jenny Phillips.

On balance, the case for nurse practitioner prescribing is presented positively and forcefully by drawing on the moral high ground of consumer need ('I'm surprised they don't look at the need out there') and by borrowing another of the 'master's tools', that of evidence-based research, to produce a more legitimate claim to authority than the argument against it. As a technique of governmentality, control over knowledge production is an essential element in the construction of discourse (Naughton, 2005). However, medicine relied on traditional techniques of hegemony, surveillance and normalisation to secure its position, but would have done well to draw on its own evidence-based discourse, or refute the nursing research in order to align popular opinion with that of medicine.

What is evident in this polemic is a shift in the structure of existing forms of power as nursing began to engage productively in its own governance, while medicine naively reasserted its traditional governance techniques over a hitherto, docile nursing workforce. Disciplinary techniques of normalisation and surveillance were also used by the anaesthetists (discussed next) and reflect the allied and concurrent purpose of the NZMA and Society of Anaesthetists to prevent, moderate or delay the implementation of nurse practitioner prescribing (Cassie, 2005b).

The anaesthetic effect

This section takes its title from an interview with Foucault about how his work has been criticised for its anaesthetising effect on people who can see the validity of his critique but "no longer know what to do" (Foucault, 1991d, p. 84). He suggests that if people are looking for solutions they may be *paralysed* – but not at all anaesthetised – as they are awake to being irritated and unsettled, which is precisely the intention of all Foucault's work.

The effect on the community of anaesthetists in New Zealand of suggestions that nurse practitioners, in the peri-operative area of practice, could administer anaesthetics was indeed, an irritant and provoked a response that ran in tandem with medical resistance to nurse practitioners prescribing independently. Despite vigorous debate between the Nursing Council and the Australian and New Zealand College of Anaesthetists (ANZCA), a pre-emptive attempt to have anaesthesia designated a restricted activity[71] under the HPCA Act, 2003 ("Good night nurse," 2004) and threats of legal action, nurse practitioners working in peri-operative care were finally prevented from administering anaesthetics by the exclusion of anaesthetic agents from the medicines schedule under the Medicines (Designated Prescriber: Nurse Practitioners) Regulations, 2005. As a tactic to paralyse the advancement of nurses' work into the medical specialty of anaesthetics, this last minute manoeuver proved to be highly effective.

The following excerpt is from an article published in *Kai Tiaki* written by Mark Bukofzer, president of the New Zealand Society of Anaesthetists and the response from the Chair of the Nursing Council, Annette Huntington:

> … The training required for the proposed scope of practice of NP perioperative anaesthesia is qualitatively and quantitatively lesser to the present ANZCA training. It is the level of training, rather than nurse anaesthetists per se, that is our concern.
>
> Despite allegations, medical specialist anaesthetists have no desire to 'exert control over the nursing profession'. On the contrary, we recognise that high quality anaesthesia delivery is dependent on the smooth functioning and interaction of a team working collaboratively … It is the potential breakdown of this team approach at the 'coal face' which is of major concern to us … (Bukofzer, 2005, p. 19).

[71] Restricted activities include: Surgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes or teeth; Clinical procedures involved in the insertion and maintenance of fixed and removable orthodontic or oral and maxillofacial prosthetic appliances; Prescribing of enteral or parenteral nutrition where the feed is administered through a tube into the gut or central venous catheter; Prescribing of an ophthalmic appliance, optical appliance or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight; Performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner; Applying high velocity, low amplitude manipulative techniques to cervical spinal joints (Ministry of Health, 2005).

Nursing Council chair Annette Huntington responds:

Like the New Zealand Society of Anaesthetists the focus of the Nursing Council is always patient safety. The Council believes that it, with the support of the nursing profession, has developed a robust and rigorous process for ensuring nurse practitioners (NP) are safe to practice in their chosen clinical areas. To date, medical colleagues have been involved in the NP approval process and this would be the case if a NP applicant wanted to administer anaesthetics as part of his/her practice in the area of peri-operative nursing … (p. 19).

The differentiation between nurse practitioner training in anaesthetics and the training of anaesthetists highlights the relationship of power determined by the normative of 'qualitatively and quantitatively' superior education opportunities provided to doctors by the ANZCA. The issue of education is not addressed specifically by Annette Huntington, who stresses the 'robust and rigorous' approval processes for all nurses seeking nurse practitioner registration. An applicant would require a clinical master's degree tailored to peri-operative care, but this alone would be insufficient to obtain registration as a nurse practitioner. She refers instead to the assessment of competencies made by a panel of experts, one of whom would be an anaesthetist. Thus nurse practitioner competency in the administration of anaesthesia would be determined by an anaesthetist who would make an honest assessment in the interests of patient safety, disinterested in political arguments for, or against, 'nurse anaesthetists per se'.

Dr Bukofzer refutes allegations of the desire to 'exert control over the nursing profession' and within the context of his concerns about 'level of training' such accusations might indeed seem irrational. However, Fedher (2003) reports there are more than 28,000 actively practising certified registered nurse anaesthetists (CRNA) in the United States, who provide 65 percent of the 26 million anaesthetics given each year and earn a reported median annual salary of US$105,000. Even accounting for scale, with these figures in mind, establishing control over a potential business competitor would appear to be a highly rational endeavour.

There is an implication in the text by Dr Bukofzer that nurse practitioner anaesthetists will interfere with the 'smooth functioning and interaction of a team working collaboratively'. As a disciplinary technique of medical surveillance, this comment serves an important financial purpose; as long as nurse practitioner anaesthetists require medical direction, anaesthetists can be reimbursed as their supervisors. The impact on public hospital salary might be negligible, but in private practice, an anaesthetist could be reimbursed for supervision of anaesthesia provided by a nurse practitioner, or even several anaesthetics administered by nurse practitioners occurring at the same time (see Fehder, 2003). A skeptical view of the importance of anaesthetists resisting nurse practitioner autonomy of practice lies less with concerns for public safety and more with protecting future profitability in private practice. As Fairman (2003, p. 56) points out, "in a very real sense, payment for services is an indication of the power and independence of the provider and those not paid [directly] remain invisible and economically dependant upon other groups".

Overall, this text illustrates a range of disciplinary techniques used by the anaesthetists to contain the shift of nursing into medical territory and re-establish nurses as docile and useful to medicine. Normalisation of existing training practices for anaesthetists are stressed, as well as the importance of medical supervision of nursing practice in the interests of public safety. Customary practice is all that restricts a nurse from undertaking 'medical' practices such as anaesthesia and there are no legal restrictions on practice generally, other than the restricted activities list contained in the HPCA Act, 2003. The Ministry of Health consulted widely on the proposed restricted activities list and the anesthetists sought unsuccessfully to have anaesthetic administration included on it ("Anaesthesia not an option," 2005). The following interview text, however, introduces the strategy of domination when more conventional strategies proved to be ineffective:

> *The anaesthetists did get desperate and tried to make it a relationship of force. In the end they used the strategies they could, they were intrinsic strategies. Legally they decided not to take us [NCNZ] to court, which was the threat initially, because they could then sense over the next 18 months that was not going to work to their advantage. But once they realised that*

if they threatened to take the Minister to court they had a huge lever. So there was a force component as they came down to the wire (NCNZ [2], p.1).

This interview text suggests there was a determined effort by the anaesthetists to prevent nurse practitioners independently administering anaesthesia. The speaker twice describes the situation as threatening as the anaesthetists became increasingly 'desperate'. 'A force component' is used in connection with coming 'down to the wire', suggesting there was sustained pressure until the very end. An element of force is evident in the minutes of the New Prescribers Advisory Committee, which record that "the Society of Anaesthetists has alluded to the potential for a judicial review if their concerns are not considered" (NPAC, 2005, June 21, item 6, para 4). The threat serves to reinforce the power of this group of specialists, their links with the legal community and their ability to finance a legal challenge. Nurses are traditionally without these connections and without the resources to finance them, although in the event of a legal challenge, the Nursing Council would be obliged to meet the associated costs.

The anaesthetists abandoned legal action against the Nursing Council as they realised the impression created by a powerful group of doctors threatening litigation against the nursing profession was unlikely to win public support ('not going to work to their advantage'). Rather, a far more effective strategy was to turn attention to the Minister of Health and delay a decision on prescribing until after the forthcoming election. With the election looming and no guarantee of the Labour party returning to office, further delays could mean a project this Minister had championed through two political terms, may not have come to fruition on her watch, without a compromise solution being reached.

The leverage this threat brought was a concession to the final deal brokered for the nurse practitioner prescribing regulations. That is, nurse practitioners would have access to the Schedule of medicines contained in the Medicines (Designated Prescriber: Nurse Practitioners) Regulations, 2005 and the Misuse of Drugs Amendment Regulations, 2005, but not neuro-muscular blockers, anaesthetic inhalants and anaesthetic induction medicines. These were deemed to be inappropriate medicines for nurse practitioners to prescribe until such time as

"appropriate training programmes have been developed and approved by the Nursing Council" (New Prescribers Advisory Committee, 2005, p. 2). This news was "warmly welcomed by the anaesthesia community", along with the suggestion that work could now begin with the Nursing Council "to develop advanced scopes of practice in fields such as acute and chronic pain and recovery room care" (O'Connor, 2005, p. 11) – areas of considerable nursing autonomy and expertise already.

The ability to even consider legal action against a Minister of the Crown represents the extraordinarily powerful position of this group of specialist anaesthetists to resist an incursion of nursing autonomy into medical territory. In a play of wills (Dreyfus & Rabinow, 1983), expertise, training, financial resources and exquisite timing, positioned the anaesthetists as more dominant than the Minister. It became a relationship of force as the wrangle threatened to derail nurse practitioner prescribing as a whole. The anaesthetic effect has been to 'put to sleep' the possibility of nurse practitioner anaesthetists in the meantime, but as with all anaesthetics, reversal might be possible when the prescribing regulations are reviewed under the Therapeutic Products and Medicines Bill introduced to the House in 2007.

Strategic game playing

Concurrent with medical opposition to broader access of nurse practitioners to prescriptive privileges were complex legal impediments. The Nursing Council worked diligently with the Ministry and its legal advisors and acted upon the advice they were given. However, this advice kept changing and resulted in yet another round of consultation, unfairly positioning the Council – not the Ministry – as inadequate for the task. The Council were the subject of considerable public comment over the delays, particularly within nursing circles (Cassie, 2005a; "The nursing year in review," 2005). The following section outlines the protracted engagement in strategic power games that preceded the necessary legislative change to the Medicines Regulations, 1984.

Given the impending replacement of the Nurses Act, 1977 with the HPCA Act, 2003 and the cumbersome processes of NPAC to introduce new categories of

designated prescribers, the plan the Nursing Council initially proposed in September 2002 was for one regulation for nurse practitioner prescribing instead of separate regulations for each area of practice. This proposal included open access to the schedules:

> *… we put up a proposal for nurse practitioner prescribing because we actually thought it was more achievable and we've stuck to that ever since, with open access to the schedule. Now the Minister has signed off on that … and instructed the Ministry to actually implement it, basically that's the policy she wanted. We kept thinking, and what's really frustrating about the whole journey, is we kept thinking we were there and then we're not, there's another, there's just been continual hurdles. Of course the whole thing's played out against cost and opposition from some parts of the medical profession – but not all – because many doctors are really supportive … The key opposers are actually the College of GPs and the Rural GP Network … there are strong groups of medical practitioners who have fought nurse prescribing all the way through (p. 7).*
>
> …
>
> Jill: It's hard not to think about it being a conspiracy, isn't it?
>
> *It is quite hard. But I am not sure; I'm not committing myself even privately to thinking it. It is hard, I mean, they're doctors and they're being lobbied strongly by the medical groups (NCNZ[1], p. 14).*

The speaker describes the process for getting nurse practitioner prescribing into law as a 'really frustrating' 'journey' of 'continual hurdles' that never seemed to end. Even the power of the Minister to instruct the Ministry on her wishes was not sufficient to overcome the legal impediments encountered and she too, described the process as the "frustration of the nurse prescribing saga" (Annette King in O'Connor & Manchester, 2005, p. 12). This was particularly so, as the Nursing Council strategy to use the HPCA Act, 2003 as the regulatory vehicle had already been endorsed by the Minister in September 2002. On the Ministry's advice, in May 2004, Cabinet agreed to change the regulatory framework to give designated prescribers access to the full medicine schedule and these changes would come into effect at the same time as the HPCA Act (M. Clark, 2005). However, subsequent government legal advice said the proposed regulatory changes were

ultra vires, or illegal and the regulations could only enable independent prescribing from a schedule of medications of generic classes. The generic classes were later also deemed by the Ministry's legal advisors to be *ultra vires* and generic lists configured to match the first schedule of the Medicines Regulations, 1984, were required (M. Clark, 2005). The changes as advised were made by the Nursing Council and, as mentioned, were approved by Cabinet under urgency immediately prior to the 17 September 2005 election.

The legal impediments in themselves were complex but more significantly, each change to the legal position brought a fresh round of consultation, which in turn provided a fresh opportunity for opposition to nurse prescribing to be voiced. In all, there were six rounds of consultation initiated by either the Ministry or the Nursing Council. The speaker (above) acknowledges the support from some doctors, but names the RNZCGP and the New Zealand Rural General Practice Network and describes them in fighting terms as strong opposing groups. The speaker later in the interview, when asked if she thought there was a conspiracy within the Ministry to block nurse prescribing, would only acknowledge that officials were doctors and '*they're being lobbied strongly by the medical groups*'. Other participants interviewed for the study more directly identified Ministry officials as obstructive:

> *I've actually [told the Minister] that what we are trying to do is being deliberately and calculatedly blocked by the Ministry (the College, p. 11).*
>
> *…*
>
> *But I mean I'll be blunt with you, in the Ministry of Health, predominantly doctors, predominantly been there a long time and they are wonderful blockers (NCNZ[3], p. 5).*

In Foucauldian terms, hindrances and stumbling blocks and the play of strategic games are a tactic of governmentality. Truth is formed in game playing and "certain forms of subjectivity, certain object domains, certain types of knowledge come into being" (Foucault, 1974, para 15). With this in mind, these tactics are productive and reproduce a position of governance for medicine over nursing issues. The succession of consultation rounds provided repeated opportunities for doctors (and other stakeholders) to have their say, re-establishing the truth and

importance of medical governance of nursing over and over again. Foucault argues strategic games do not "necessarily mean that power is exercised against the interests of the other part of a power relationship" (Lemke, 2000, p. 5) and may in fact empower them. Indeed, this may have been the case for nurse prescribing, in that once the requirements for consultation had been fully met (to the satisfaction of the Ministry), there were no further impediments to the Minister taking the regulations to Cabinet for approval. The Minister had already indicated her intention to proceed, despite the concerns of doctors, and the power of her office did permit a final and domineering standpoint.

Ex post facto

After the fact of the passing of the regulations, a final struggle to contain prescribing within a medical discourse reintroduced the theme of supervision of nursing work. Once again, medical supervision is presented as vital to effective teamwork. An editorial highly critical of nurse practitioner prescribing appeared in the *New Zealand Medical Journal* (the official journal of the NZMA) the day after the new regulations were published by the Nursing Council in the *Gazette* (NZ Nursing Council, 2005, November 10). As well as re-presenting the same concerns as the anaesthetists and Dr Boswell about "lesser" education, the editorial proposed that independent nurse prescribing would threaten the standard of health care in New Zealand. A renewed focus on fragmented teamwork was reinforced by the example of the deleterious precedent of midwifery independence:

> Good medical care depends on teamwork. Teamwork is effective when each member of the team recognises their own role and the superior capabilities of other members of the team in their roles. Duplicating activities and roles undermines this principle, and thus independent nurse prescribing will damage teamwork (Moller & Begg, 2005, p. 1).

In the first instance, this text (contestably) locates health care as 'medical' care, establishing health not as a shared activity within a heterogenous team of practitioners, but as the province of medical practitioners. The value of 'good' is ascribed to this arrangement. A *prima facie* reading suggests an egalitarian concept of teamwork is espoused, however, the authors divide the team into those

with ‘superior capabilities’ and others with, presumably, inferior capabilities; nurses, no matter how well educated, do not meet the criteria for inclusion as capably superior. This differentiation incurs a hegemonic relationship of power with some roles clearly subordinate to others. The onus is placed on the subordinate roles to maintain the cohesion of the team by not disrupting the given order and certainly not ‘duplicating’ any activities performed by those with superior capabilities. The logic internal to this text, is of a hierarchical principle of teamwork, which allows for the view that independent nurse prescribing will be ‘undermining’ and ‘damaging’ to an otherwise ‘good’ arrangement.

Furthermore, as Larson (1977) points out, “superior cognitive rationality appears to establish the superiority of one professional ‘commodity’ *independently* of the interests and specific power of the group … (p. 41). Thus the presentation of a rational argument for the maintenance of cooperative teamwork, in the interests of patient wellbeing, serves to objectively disguise and separate the inherent power and financial interests that underlie medicines’ rejection of independent nursing action. Interestingly, the reaction of New Zealand physicians to nurse practitioner prescribing has mirrored the reaction of physicians in the United States, who couch concern about competition as concern for public safety (Fairman, 2003; F. Hughes, 2002).

The Nursing Council scope description of nursing practice locates collaboration as central to nursing practice. It conveys ideas of sharing, partnership, interdependency and power shared amongst team members (D'Amour et al., 2005). However, as illustrated by the text written by Moller and Begg (2005), collaboration within a medical discourse carries a subtext highly suggestive of supervision. Pippa Hall (2005) suggests the tradition of medical education socialises physicians to be independent and highly competitive academics; whereas nurses are socialised towards working collectively in teams, to solve problems together, and exchange information across shift changes to facilitate continuity of care. Thus within a medical discourse, it is only possible to speak (and conceive) of physicians taking charge and assuming responsibility for decisions; and within nursing discourse, for nurses to assume an egalitarian and corroborative partnership. The superiority of medical knowledge and authority

legitimates the disciplinary practice of surveillance of nurses' practice and reproduces a relation of domination.

Moller and Begg's (2005) decision to lodge their disapproval at such a late date provided an opportunity to publicly respond to concerns about teamwork (Bickley-Asher, 2005; Renouf, 2005) and called for reciprocal collaborative practise from medicine. With the regulations otherwise safely passed, different medical groups recanted their previous opposition and lent cautious support for nurse practitioners and prescribing. Two medical groups previously strident in their opposition wrote, "The addition of nurse practitioner prescribers will strengthen primary health teams" (J. Fox, 2005, Sept 13); and of nurse practitioner's in general, "Ultimately nurse practitioners should not be viewed as a threat, but as another opportunity to deliver high-quality health care to patients" (Malloy, 2006, p. 6). These statements come with the familiar caveat highlighting the importance of collaboration in teams. Essentially, however, they mark an important point of transition in medical acceptance of a nurse practitioner role that includes prescriptive privileges.

Summary

The introduction of the nurse practitioner role introduced a discursive shift that challenged medical ownership of clinical practices by bringing the practices, or 'tools', of assessment, diagnosis and prescribing into general nursing discourse. Resistance to widening prescribing privileges for nurse practitioners followed, with prescribing being seen as a medical practice central to business profitability, but couched to the public in terms of risk to safety.

Not only challenging the limits and forms of the *sayable* within a nursing discourse, the struggle over independent prescribing for nurse practitioners ushered in another discursive shift, propelling nursing and in particular the Council, into an autonomous role in the governance of nursing, thereby defying traditional medical 'rights' for control of nursing issues. Drawing on the academic discourse that had informed the creation of the nurse practitioner role, nursing leaders articulated their legitimate position of authority on nursing matters, making reference to the supporting international evidence.

When efforts to impose direct medical surveillance of nurse prescribing practice failed, physicians resorted to insisting that nurse practitioners work collaboratively, or risk damaging the standard of health care in New Zealand. Nurses understand practice autonomy as being free from the *requirement* for physician collaboration or supervision. The freedom of nurse practitioners to choose to engage in collaborative practice in the interests of improved health services is discussed next. Using Foucauldian notions of governmentality and technologies of the self as theoretical tools, a potentially new and liberating identity for nurse practitioners forms the focus of the following chapter.

Chapter 10: New Positionings

Introduction

As the final analysis chapter of the thesis, the intention is to consider "the possibility of new and potentially more liberating modes of subjectivity" afforded by the nurse practitioner role (Allen, 2000, p. 125). Whereas chapters eight and nine considered the constraints on new nursing ventures imposed by a discourse of ownership, this chapter foregrounds representations of New Zealand nurse practitioners.

Although nurse practitioners work across primary, secondary and tertiary level health care settings, as with chapter eight, the focus of discussion remains on the primary sector, which is often marginalised in comparison to the attention given to secondary acute services, elective surgery and District Health Boards. Current state investment in primary health care services, under the aegis of the PHC Strategy (2001), continues to increase and offers considerable scope for advanced nursing skills particularly as the private business model of general practice is threatened by general practitioner disenchantment. Further marginalised within PHC discourse are the non-profit, non-government organisations known as the third-sector (Crampton, 1999). Often Māori health providers in rural areas, these organisations already conform to the regime of the PHC Strategy, shaping the possibilities for nurse practitioners in different ways to the private practice model.

Foucault's (1991b) notion of governmentality will continue to be used throughout the chapter, but with a greater emphasis on what he called the 'technologies of the self'. By this he means "the processes by which the individual acts upon himself" (Burchell, 1993, p. 268) and in this chapter, how these reinforce the techniques of government found in the PHC Strategy (2001).

The chapter, therefore, focuses on *possibilities* and examines a potentially new and liberating identity using the notion of hybridity derived from post-colonialist theorists (Bhabha, 1994; Bolatagici, 2004; Hutnyk, 2005; and Young, 1995). The way in which nurse practitioners describe their practice and are represented from

within this space suggests they contribute to a qualitatively different type of health service. The shift from medical surveillance of nursing practice to new techniques of self-governance is examined and, using the practice of prescribing, possibilities for a new normalcy of trust between the two health professional groups. Finally, the political positioning of nurse practitioners as leaders and advocates for equitable and accessible health services is presented as the clear and conscious aim (Foucault, 2004) of *most* expert nurses, as they practise from this interstice.

A new and liberating identity

Within New Zealand nursing discourse, appropriation of the tools of diagnostic practices of physical assessment and diagnostic studies (such as laboratory tests, X-rays and other imaging procedures) and prescribing into advanced nursing practice, has led to debate about a reconstruction of nursing "within an interventionist/curative paradigm – a medical paradigm" (Litchfield, 2002, p. 20). Litchfield's concern is the nuances of knowledge that differentiate nursing from medicine would be lost in what could ultimately become a "generic health worker model" (p. 20). The objectification of the body through these practices results in a diagnosis, which is thereafter treated "as an unambiguous objective entity physically embodied in the patient" (Yardley, 1997, p. 8 - 9). It is the primacy of the discursive dimension of biomedicine that post-structuralist interpretations question because of the secondary importance given to possible social and psychological experiences (Yardley, 1997). A study participant also questioned the importance placed on the medical paradigm:

> *"So to me nursing is the whole and medicine is the fragment of it. And if we need to hook some of medicine's tools to do our job properly then so be it: I actually don't care. I think the tools are irrelevant … it's not what we do - its what's in our head while we're doing it that determines our practice" (the College, p. 7).*

Nonetheless, concerns about a 'generic health worker model' are not confined to nursing and have also been expressed by medicine. Specifically, the Australian Medical Association has raised the notion of hybridity. Intended to be disparaging, hybridity positions nurse practitioners in theoretically useful ways:

> We must also put an end to the recent dangerous pursuit by some groups and individuals for a new breed of hybrid doctor-nurse medical professionals (Dr. Mukesh Haikerwal in McDonald, 2005, p. 1).

Referring to nurse practitioners, the speaker is positioned clearly in opposition to this 'new breed' of professional, considering them to be a 'dangerous pursuit' that must be stopped. His talk of 'breed' and 'hybrid' casts this medical project in the context of lineage and perhaps, even, pedigree. Hutnyk (2005) discusses the many ways hybridity is used theoretically, one of which is the rejection by British colonial purists of 'half-castes' and 'mulattos' because of their misfit with the binary ideal of racial separation. Haikerwal's comments can be read as positioning the 'hybrid doctor-nurse' in the same disparaging light as the colonialist's notion of half-castes, presenting such professionals as a departure from the ideal of clean lines of descent that would see nurses staying within a nursing career path and doctors staying within their own also. All the same, as Young (1995) suggests, the purity of any bloodline is always open to debate, as are "discussions of human 'races' as distinct species" (Hutnyk, 2005, p. 82). This is exemplified in the knowledge that is borrowed and shared between all of the health professional groups.

A more useful theoretical application of hybridity, perhaps, is the way in which hybrid plants can be propagated. There are two main methods; 'sexual' hybrids (by cross-pollination) and 'graft' hybrids. Of these two, the notion of a 'hybrid doctor-nurse' is most analogous to graft hybrids, simply because nurse practitioners are not genetically determined (or bred), but are the result of considerable personal effort in education and practice achievement. In the grafting method of propagation, two different species within the same genus[72] are grafted together in order to produce a composite plant that maintains the special characteristics of both and is superior to the original plants (Hartmann et al., 1997). A 'scion' is grafted on to a 'rootstock' plant, in any desired position from below ground level to high on the branch of a tree. The risk if pruning is neglected, is the rootstock can take over the scion and the special characteristics

[72] Grafts can be made between genera but within a family, or even between families, but are likely to be unsuccessful (Hartmann, Kester, Davies, & Geneve, 1997).

of the hybrid will be lost (the reverse, of scion taking over the rootstock, is not possible).

Based on the hybrid graft analogy, the intention for New Zealand was for a nurse practitioner to be formed on nursing rootstock with a medical scion of diagnosis and prescribing practices grafted in. The concern expressed by Litchfield (2002), using this analogy, was for the reverse; that the rootstock of the nurse practitioner would be fundamentally medical and the scion nursing, with the risk of the medical rootstock, taking over. There is the idea that borrowing from medicine somehow weakens nursing culture (Hutnyk, 2005), yet there is much within 'conventional' nursing practice that is similarly borrowed. For example, measuring temperature, pulse and blood pressure was the exclusive domain of medical practice only fifty years ago (Carryer, 2005b). These blurred and permeable boundaries that accompany task distribution between the professions are easily confused with the fundamental philosophical differences between nursing and medicine. The central issue is the way in which the practices of diagnosis and prescribing are informed by each discourse (illness versus wellness). In her reply to Litchfield (2002), Carryer (2002) challenges the focus placed on diagnosis and prescribing and relegates them to the place of convenient "practice tools" (p. 23) that, as mere tasks, they cannot account for the philosophical shift Litchfield prophesies.

The "making one of two distinct things" achieved in hybridity is discussed by Young (1995) as making "difference into sameness, and sameness into difference, but in a way that makes the same no longer the same, the different no longer simply different" (p. 26). He draws on the logic of Derrida to describe the sense of "a breaking and joining at the same time, in the same place; difference and sameness in an apparently impossible simultaneity. Hybridity thus consists of a bizarre binate operation … [a] double logic, which goes against the convention of rational either/or choices …" (Young, 1995, p. 26 – 27).

The either/or categorisation of patient's complaints as either medical, or not, is discussed by Fisher (1995) in her analysis of patient encounters with doctors and with nurse practitioners. Patient complaints that are not medical leaves the doctor

without another role available to him, whereas nurse practitioners are able (in 'an apparently impossible simultaneity') to draw on nursing *and* medical knowledge to legitimise the experience a patient describes.

Departing from fixed understandings of 'essential' identity, Bolatagici (2004) develops the notion of hybridity to suggest not only the possibility for a new identity, but a new and liberating form of identity. Eluding the politics of polarity (Bhabha, 1994), the nurse practitioner could therefore, embody a space between the black and white (Bolatagici, 2004) of doctor and nurse. It is a space of in-betweenness, a third space through which "newness enters the world" and subverts "the authority of the dominant discourse" (Sakamoto, 1996, p. 116). Thus the nurse practitioner could be understood as a whole new identity and not as half of two things that have been catalogued as different (Bolatagici, 2004).

That Haikerwal (in McDonald, 2005, above) rejects the idea of a hybrid professional outright, indicates his discomfort with the undermining of familiar fixed and unitary categories of practice and the transgression of traditional boundaries (Bolatagici, 2004). The simple and pure binary of doctor/nurse that is replaced by a "bizarre binate" of nurse practitioner, is irreconcilable to a discourse that has traditionally privileged medicine. The new identity is an unknown to medicine but the signals of "a liberating location of progressive resistance" (Bolatagici, 2004, p. 75) are 'dangerous' and must be 'put to an end'.

Bhabha's (1994) notion of an alternate 'third space' identity for nurse practitioners has considerable appeal, but the adherence to an essential *nursing* identity is evident in the competencies for practice (NZ Nursing Council, 2004b; G. Gardner, Carryer et al., 2004) and in descriptions of nurse practitioner practice (for example, Fisher, 1995; Maloney-Moni, 2004; Renouf, 2002). Consequently, of greater resonance is the construction of the nurse practitioner as one of both insider and outsider to both nursing and medicine; impossibly and simultaneously alienated and aligned.

Practising in the interstices: Nurse practitioner voices

Constructing the nurse practitioner as both insider and outsider to nursing and medicine creates a new space or interstice from which to practise. This section foregrounds the discourse of nurse practitioners and the way in which they represent themselves and their practice from this space. Julie Fairman (2003, p. 59) suggests the conceptualisation of nurse practitioners within "a new hybrid paradigm of care" avoids "the intellectual trap of comparison with the 'mean' of the dominant paradigm of medicine" and "embraces the power and agency inherent in the knowledge and practice of NPs". There is a certain freedom in this interstice to go beyond the limits imposed by convention and the Nursing Council scope description to construct a unique version of expertise that draws upon multiple disciplinary discourses including, but not limited to, those of nursing and medicine.

Highlighting the difference in discourse that informs medical undergraduate preparation, from the multiple discourses informing nurse practitioner practice in primary health care, is the following excerpt from a contribution to an informal email discussion group written by New Zealand's first nurse practitioner to prescribe, child-youth NP, Paula Renouf, with the subject line 'Nurses doing primary care': [73]

> Medical training provides a paradigm for the management of many things, but not the real 'primary care' level pathologies of our time: social, family and lifestyle, life choice, nutritional and cultural/immigration issues (going far beyond an understanding of te Tiriti o Waitangi). … We must not fall into the trap of just imitating a medical model in clinical training of NPs. The primary care NP/clinician needs both a solid scientific base and coursework in management of common primary care conditions, chronic illness partnership, primary health care: the big picture AND specific post graduate courses in application of family theories, developmental psychology, behaviour change theories, youth development, multicultural competence and mental health therapies and strategies to the range of

[73] The original post can be viewed at the College of Nurses Aotearoa discussion board archive http://www.nurse.org.nz/discussion.htm#archive Minor formatting changes have been made to improve clarity. Permission to use the text was granted by the author.

> problems which confront us in primary care (and a second language or two needs to be more actively encouraged/ or even compulsory in this day and age?) In this way, how could we EVER be perceived as 'duplicating doctors', or 'being minidocs', or being 'unsafe prescribers', or 'threat to the NZ population'? (July, 2006).

This text illustrates the limitations of medical model training to address what is termed the 'real primary care level pathologies of our time'. The determinants of health beyond 'common primary care conditions' and 'chronic illness' *are* addressed by nurse practitioner practice, informed by disciplinary knowledge drawn from a range of social sciences, including sociology, psychology and psychiatry. In this context, the conventional contribution medicine makes of diagnosis and treatment seems relatively insignificant and the suggestion that NP practice 'duplicates' medical practice, or is a lesser 'minidoc' version of medical practice seriously undermines the level of expertise offered by a nurse practitioner. The traditional positioning of medical knowledge as the final authority on all issues related to health and wellbeing, serves to position other knowledge as secondary and having less importance; yet medical knowledge represents just a fragment of the whole that nurse practitioners offer.

Further to the use of 'other' knowledge to inform the discourse of nurse practitioners, Janet Maloney-Moni (2004), New Zealand's first Māori nurse practitioner in primary health care, describes (below) just one aspect of the kaupapa[74] Māori framework of her practice, which is characterised by "a deeply embodied sense of personal knowledge" (p. 58):

> Kua tatari is to wait until 'the time' I am asked to provide any type of care for my clients. I waited six months before I was able to support the kuia[75] with the ulcers and six months before I was able to support the kuia who is grieving for the loss of her son. I waited one year before the wife of one of my clients spoke to me. The practice of waiting is common for what I have been taught in my role as teina[76] in my immediate family and my extended

[74] A strategy, theme or practice that is specific to Māori culture
[75] Elderly Māori woman
[76] Younger member of a whanau

> family. The ages of my clients are also an important part of this practice. Many of my clients are kaumātua[77] and I have been taught to be respectful of all our elders (Maloney-Moni, 2004, p. 166).

Knowledge of how to wait is an example of embodied personal knowing that developed from growing up in a whanau and learning about the proper approach a younger whanau member must take when approaching an older person. Showing respect takes time, perhaps as long as a year, for there is little to be gained by intervening before a person is ready. The primacy of medical knowledge in this context is relegated well below the primacy of a culturally safe approach to establishing a relationship of trust. The power relationship is entirely reversed from the expert model of dispensing care to simply waiting 'until the time I am asked to provide any type of care', despite being aware of particular health concerns such as unhealed ulcers and unresolved grief.

The complexity of the knowledge used by nurse practitioners to work with individuals and families makes the arguments over the incorporation of 'medical tools' into NP practice seem incongruous. Yet physicians interpret the utilisation of diagnosis and prescriptive privileges as making nurses the same as doctors because they "perform the same tasks" (J. Adams, 2002, August 15, para 13). Serving to normalise the integration of medical practices into everyday nursing practice, the following photograph shows a nurse practitioner ready to perform many of the 'same tasks' a doctor would undertake in this instance, in the critical care of a neonate.

The following photograph was published in the New Zealand lifestyle magazine *Next,* in June 2002, as part of a feature article about Deborah Harris, New Zealand's first nurse practitioner in neonatology. The caption accompanying the photograph reads "Deborah's job includes helping transport sick babies from outlying areas to Waikato Hospital's neonatal intensive care unit" (Hoffart, 2002, p. 36).

[77] Elderly Māori person

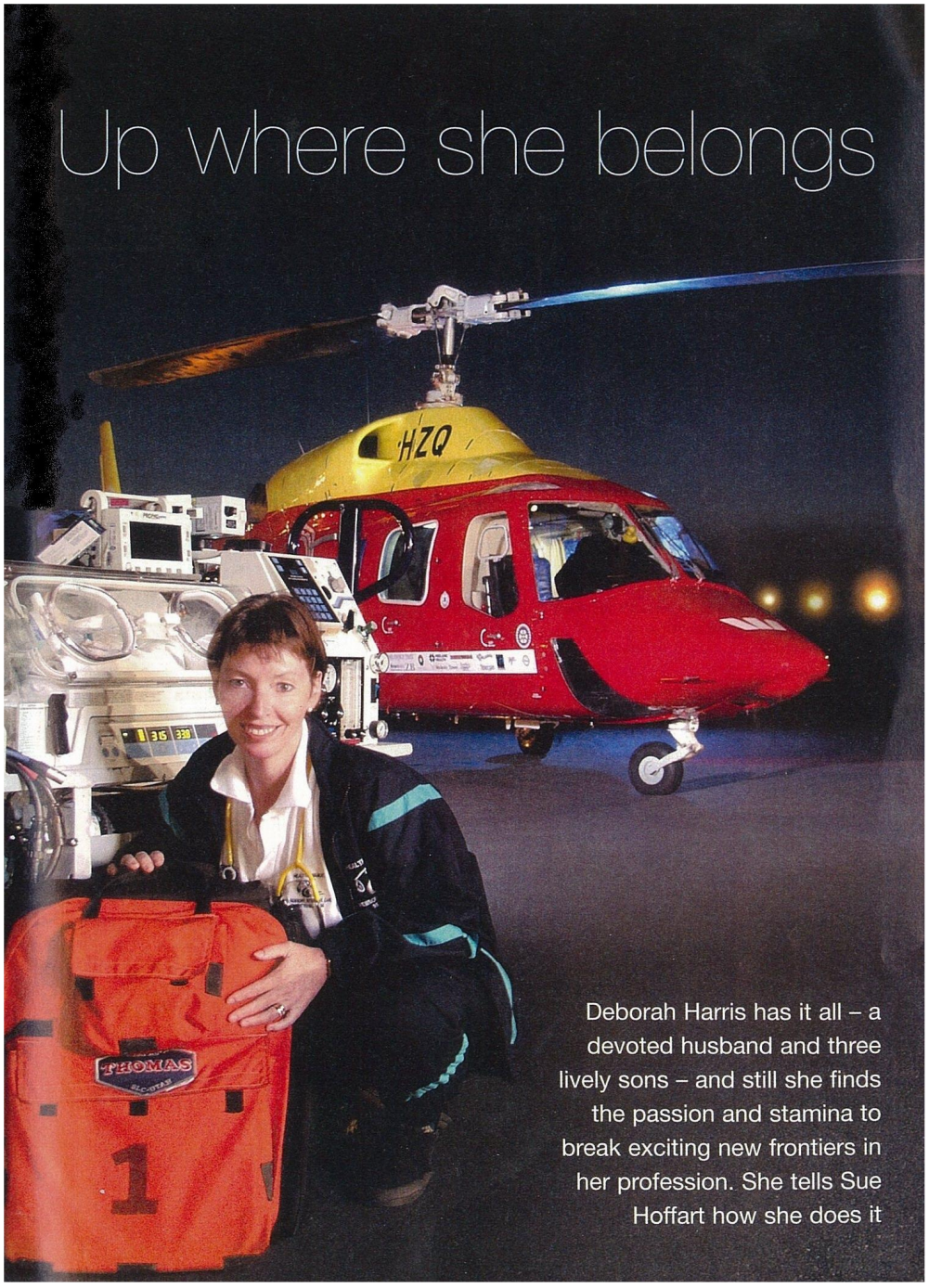

Figure 1: Is that a nurse? Stu McKellar Bassett, (photographer). 2002. Used with permission.

The importance of this photograph lies in its "capacity to create and not merely depict" a new public discourse that constitutes nursing as a learned profession, concerned with advanced knowledge and complex skill (Fealy, 2004, p. 655). Given this is a lay depiction of nursing (the author is a freelance "lifestyle" writer), what is striking about this photograph is its positive message and absence

of a traditional nursing stereotype. Instead, Deborah is represented as a mature, professional woman, employed in a specialist area of nursing work. She is an autonomous and skilled practitioner in charge of the well-being of a fragile neonate, including a state-of-the-art transport incubator, replete with ventilator, cardiac monitor and oxygen supply. Positioned alone in the foreground, she is clad not in a white nurse's smock but in a practical hospital issue track top and pants, a paediatric stethoscope is around her neck and she is holding a large equipment bag. The technical skills needed to care for critically ill neonates draw on medical practices of assessment and advanced airway management, and the stethoscope and 'doctors bag' are symbols normally associated with those practices. Yet Deborah is a nurse and this photographic image disrupts what has been the dominant view of the nurse as a trained worker and assistant to the doctor – particularly as no doctor is present.

Where the scope description under the HPCA Act, 2003 legally bounds a nurse practitioner's practice, so too a public discourse, based on its ideals and values about what nurses should do, constructs boundaries that confine practice in powerfully similar ways. Thus a *Next* reader is likely to consider his or her existing beliefs about nursing work and compare them to what is presented in the photograph and article. The image deliberately challenges the reader to consider nursing as a changing and dynamic occupational identity, in contrast to the immutability of historic constructions (Hallam, 1998). The caption "Up where she belongs" with its double meaning of flying in the helicopter and the elevated status of nurse practitioner, suggests Deborah is authorised as 'belonging' there because of her expertise and education. Combined with the symbols that denote a higher office (stethoscope and bag), the overall impact is one of nursing's shifting boundaries.

Where once nurses were unmarried and without dependents, the text on the right lower corner of the photograph positions Deborah as a new 'ideal' nurse who "has it all": husband, three sons, as well as being a pioneer in her profession. This new identity for nursing has political and economic significance as nurses as women engage in the 'impossible triangle' of contradictory discourses, those of sex, work and motherhood (Kaplan, 1990).

Each of the representations of nurse practitioner practice presented in this section foreground *nursing* as the central discourse and medicine as a subsidiary. Even the photograph of Deborah Harris, surrounded by medico-technical equipment and clearly equipped with the skills and tools to perform advanced physical assessment, positions her firstly as a nurse, within a nursing paradigm. There is, however, a particular freedom created by a hybrid paradigm of care that is initially articulated as part of the process for nurse practitioner registration (see NP competencies in appendix one). Here applicants are required to define their specific area of practice expertise and unique contribution to the field. New approaches to nursing knowledge are thereby generated and in so doing, a set of practices are constructed that in turn, constitutes their own subject position (Foucault, 1983a). For example, the practice of kua tatari used by Janet Maloney-Moni belongs to a set of practices that position her in such as way that the health care she offers is culturally acceptable. Significantly, the representation of nurse practitioners becomes one of freedom to construct a chosen subject position that is beyond the governance of medicine, or even conventional nursing subjectivities. Described by Foucault (1993) as 'technologies of the self' the techniques of self-government are examined in the following section.

(Self) governance

Possibilities for new subject positions in the governance of nursing and nurse practitioners arose initially from the Nurses Amendment Act, 1999 which changed the constitution of the Nursing Council to be comprised solely of nurses and midwives. Aside from removing the right of the NZNO to nominate members, the amendment also removed the requirement for a medical representative, namely the Director-General of Health (or delegate) to be a member, thus ending one hundred years of medical participation in the governance of nursing affairs. However, given that "nursing remains beholden to the Minister to appoint 'its' members" the appointment process is still seen by the NZNO to be an acceptance of "externally sanctioned representation" and this organisation argues that appointment should occur by democratic election of representatives from practice, as it does for doctors and dentists (Brinkman, 2006, p. 28).

The HPCA Act, 2003 further changed the nature of nursing governance by instituting competence assurance practices into the regulation of nursing, requiring the Nursing Council to set accepted levels of competence for each scope of practice and nurses to provide evidence – on request – of having met them. The Nursing Council as an institution has not changed, rather a new form of nursing government emerged as a result of a change in the practices of governance (Gordon, 1991). Having as its purpose the welfare of the population (i.e. the recipients of nursing care), governmentality "refers to a continuum, which extends from political government right through to forms of self-regulation, namely 'technologies of the self'" (Lemke, 2001, p. 201).

While the Nursing Council governs the regulation of nursing, the Nurse Practitioner Advisory Council of New Zealand (NPAC-NZ)[78] works with the Council as an independent guardian of nurse practitioner interests, providing advice on credentialing issues, mentoring programmes, policy and promoting research and evaluation of the nurse practitioner role and its development (Neville, 2002; Trim, 2002; 2004b). Formed in May 2002, as an independent advisory body following initial concerns about Nursing Council regulation and registration processes for nurse practitioners (see chapter seven), NPAC-NZ maintains surveillance of both the Council and its own practitioners via the activities in which it engages. Thus NPAC-NZ creates a "strategic reversibility of power relations" (Gordon, 1991, p. 5), reinvesting agency with nurse practitioners to legitimately challenge power structures and effectively participate in self-governance. Although the Council, in many instances, determines the possible field of action, negotiation is still possible and the domination effects implied by a statutory body remain fluid and capable of transformation.

An important power mechanism available to NPAC-NZ occurs through a planned approach to research about the role and the maintenance of a repository of research about nurse practitioners (Trim, 2004a)[79]. The production of a body of knowledge about the nurse practitioner role in New Zealand is constituted by

[78] NPAC-NZ is comprised of four major nursing associations: the NZNO, the College of Nurses Aotearoa, the New Zealand College of Mental Health Nurses, and the National Council of Maori Nurses.
[79] For example, this PhD study is registered as a project in progress with the NPAC-NZ database.

power because it determines what can be known. This in turn, determines possible subject positions and ultimately produces reality (Foucault, 1977a). The accumulation of data contributes to a regime of knowledge that can be used to influence Ministerial policy as well as Nursing Council policy and serves as a useful database to other researchers.

Recognising a shift in the structure of a truth regime is fundamental to a Foucauldian analysis of power (Naughton, 2005) and the following sections demonstrate the ongoing struggle to shift from historical constructions of medical surveillance over nursing, to nurses engaging by means of governmentality in their own professional and individual governance.

Truth-technology

The following text is an excerpt of a notice published by the Nursing Council in the government *Gazette* pursuant to the Medicines Amendment Act 1999, the Misuse of Drugs Act 1975 and the Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005. The section of text refers to the evidence of ongoing competence the Council requires of nurse practitioners who are endorsed as designated prescribers:

> **B. Other training to be undertaken (Regulation 7)**[80]
>
> Nurse practitioners authorised to prescribe within their defined area of practice, must undertake:
>
> (a) a minimum of 40 hours per year of professional development aggregated over a five year period; and
>
> (b) a minimum of 40 days per year ongoing nursing practice aggregated over a five-year period within their defined area of practice.
>
> **C. Assessments of competence to be completed (Regulation 8)**
>
> Nurse practitioners authorised to prescribe must provide to the nursing council each year with their application for a practising certificate, evidence that they have maintained their competence. As part of this assessment, all nurses authorised to prescribe must provide the nursing

[80] Regulations 7 and 8 are in reference to the Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005.

> council with evidence that they have completed the ongoing training required by paragraph B above; competence assessment; and evidence of ongoing multidisciplinary peer review of their prescribing practice (NZ Nursing Council, 2005, November 10, p. 4750).

In isolation, this notice is straightforward and outlines the activities nurse practitioners must provide evidence of to the Council, each year, in order to continue to prescribe medications. However, when compared to the 2002 *Gazette* notices for designated prescribers practising in Child Health or Aged Care (2002, November 7), there is a 150 percent increase in the requirement for professional development hours (from 16 hours per year to 40 hours) and a 300 percent increase in practice hours (from 80 hours per year to 320 hours). The 2002 notices indicated that in addition to ongoing monitoring of competence through competence-based practising certificates, nurse practitioners were also subject to five-yearly reviews. However, the 2005 notice requires the *annual* presentation of evidence of professional development, competence assessment and multidisciplinary peer review that is specific to prescribing.

Last-minute cabinet approval of the regulations just prior to the 17 September 2005 election approved nurse practitioners prescribing in all specialty areas (except anaesthesia) and was much heralded in the media. However, the intensification of Nursing Council surveillance of nurse practitioners provided for in the 2005 *Gazette* notice received little attention and was not publicly commented on by nursing[81].

Foucault's notion of governmentality links 'techniques to govern others' to 'techniques to govern the self' (Lemke, 2000) and can be usefully applied to the regulations to illustrate the constitution of the nurse practitioner subject. Foucault (1993, p. 204) suggests "Power … relations involve a set of rational techniques and the efficiency of those techniques is due to a subtle integration of coercion-technologies and self-technologies". The Council's governing and 'rational' role

[81] A secondary reference in *Kai Tiaki* appeared mentioning the NZMA's opinion that there was an "inadequate" professional development requirement (O'Connor, 2005, p. 11).

is to set the terms by which nurse practitioners govern themselves; that is, engage in the prescribed activities and collect and present evidence to the Council of such engagement. The Council then reciprocates by approving another year of the same activities. Coercion-technologies are present, in the sense that non-compliance with the regulations will result in withdrawal of prescriptive privileges. Thus an iterative circle of coercion to engage in self-technologies occurs between the Council and individual nurse practitioners that could be described as both rational and efficient, but nonetheless, involves a relation of power to which the nurse practitioner is both subject to and object of.

The exact nature of the self-technologies nurse practitioners are required to engage in (under section C above), take the form of what Foucault (1993) refers to as confession or self-examination, or 'truth-technology'. That is, an orientation "toward the permanent verbalization and discovery of the most imperceptible movements of our self" (p. 222). Applied originally to the negative self-sacrificial confession practices of early Christianity, Foucault suggests a hermeneutics of the self has developed over time to produce a more positive emergence of the self. In the context of prescribing, nurse practitioners must engage in the practice of 'confession' by verbalising and/or documenting their drug treatment decisions for multi-disciplinary peers to scrutinise and document the outcomes of such meetings as evidence for the Council. Interestingly, medical practitioners engage in peer review that is not multi-disciplinary and not specific to prescribing (see NZ Medical Council, 2005). A three-tier system of panopticon-like surveillance of nurse practitioner prescribing practice is thereby established: the nurse in self-examination; multi-disciplinary peers (other NPs, doctors and pharmacists); and finally the Council. As the final arbiter of safety to practice, the Council fills the role of 'master' in the confessional, who by its superior wisdom and seniority, is able "to distinguish between truth and illusion" (Foucault, 1993, p. 219) in the practice of the practitioner under examination.

Furthermore, the statutory role of the Council is to maintain public safety by ensuring all practitioners registered by them are safe to practice. A public safety discourse has been institutionalised in law as the means by which the Council maintains its surveillance role. There is a perception of safety when control

practices and regulations are in place and this is heightened with intensified surveillance – as with the nurse practitioner prescriber regulations. Similarly, dangerous criminals and psychiatric patients are placed in 'maximum security' under close watch in order to protect public safety. Such comparisons are useful, however, only to illustrate that those not trustworthy are subject to close scrutiny in our society, and the concessions made by the Council to have the nurse practitioner prescribing regulations approved were made to appease those groups who consider the prescribing practices of nurses to be untrustworthy.

A new normalcy: Trust

Much of the concern arising from medicine over nurse practitioner prescribing practices stems from the assumption that if a nurse practitioner acts independently he or she cannot also act collaboratively. This is typical of the either/or categorisation characteristic of modernism where such a construction suggests *either* nurse practitioner practice is collaborative and can be subject to medical surveillance: *or*, it is independent and cannot be subject to medical surveillance. To hold these two contradictory discourses simultaneously so nurse practitioners are constructed as *both* independent *and* collaborative not only ascribes to postmodern ideas of plurality, but also relies on understanding a wider range of the techniques of governmentality than the disciplinary techniques used conventionally by medicine.

In a letter to the editor responding to the Moller and Begg (2005) editorial discussed in chapter nine, New Zealand nurse practitioner Paula Renouf, describes the collaborative nature of nurse practitioner practice:

> Our objective is to improve care, improve timely access, and improve (not destroy) health care teamwork, leading by example. Indeed, most NPs will be integrally linked into some sort of collaborative practice setting with peer review and ready consultation and referral systems, whether in primary care or tertiary. However, 'dependent' prescribing means working under 'standing orders' or getting every script co-signed and neither of these is necessary or practical to an NP on a day-to-day basis. In short, we prescribe 'independently' and practice 'collaboratively' (Renouf, 2005, p. 2).

This section of text illustrates 'techniques of the self' as playing a role in the governance of nurse practitioners as they engage in 'peer review', 'consultation' and 'referral systems'. Technologies of the self are practices deployed by individuals to "actively and reflexively constitute themselves" in particular ways, in this case as collaborative practitioners (A. Allen, 2000, p. 118). "Teamwork" and "a collaborative, multidisciplinary approach" are aspects of government policy contained in the PHC Strategy (2001b, p. 6 & 18) and as a regime of truth, render the autonomous subject 'responsible' for adjusting his or her conduct accordingly (Lemke, 2000). As an exercise of power to guide conduct (Foucault, 1983b), technologies of the self are no less effective at achieving the objective of collaborative practice than if physicians were to continue with their disciplinary techniques of surveillance. However, now there is an autonomous practitioner who *freely chooses* to engage in collaborative practice in the interests of improved health services – not to appease physicians.

Dependent prescribing, on the other hand, would be as Foucault (1983b) suggests, "voluntary servitude" and he asks, "how could we seek to be slaves?" (p. 221). The call for dependent prescribing from physicians has recurred as a *leit motif* for more than a decade in New Zealand[82], but began formally with submissions to the Health Select Committee on the proposed amendment to the Medicines Act 1999 to allow nurse prescribing. Submissions supported "nurses prescribing in conjunction/cooperation with doctors" (Pegasus Medical Group, 1999, p. 2) and cautioned that "the encouragement of nurses to act autonomously inevitably runs counter to the imperative for primary care providers to work collaboratively in a team context" (RNZCGP, 1999, p. 1). But as Renouf (2005) makes plain, being dependent on medical supervision for prescribing is neither 'necessary or practical'. This is because nurse practitioners practice with a new and more liberating mode of subjectivity (A. Allen, 2000), regulated by the state, but constituted by the self (Foucault, 1993).

The freedom of an agent to determine his or her own actions (Ballou, 1998) is a condition for the exercise of power, which is "exercised only over free subjects,

[82] See Pearson, 2004 for a précis of the US experience of dependent and independent prescribing.

and only insofar as they are free" to choose from several ways of behaving (Foucault, 1983b, p. 221). It becomes a question of personal ethics to practice collaboratively, being much more than compliance with a set of rules (Foucault in Luxon, 2004). Trust then, must replace the surveillance physicians have felt necessary to maintain public safety: trust that the Nursing Council processes for registration and monitoring are sufficiently rigorous; and trust that nurse practitioners will consult, refer and review as physicians, of course, do amongst themselves.

Way, Jones and Busing (2000) stress the necessity of non-hierarchical provider equality for successful collaborative relationships, where one professional group is not dependent on supervision by another and where the strengths and integrity of contributors is recognised. Trust also, is identified by Boland and Leib (2003) as one of four components to successful collaboration between nurse practitioner and physician, the others being mutual respect, shared accountability and joint decision-making. However, they highlight physician acceptance of nurse practitioners as being dependant on past experience and exposure to NP practice. One way the Nursing Council has developed to expose physicians to nurse practitioner practice is to have a relevant medical specialist sit on the assessment panel:

> *Those docs who have been on our panels are blown away by the rigour of our process and they come out strong advocates of nurse practitioners. They come out saying, "Wow, I want one of those. She's answering those questions better than my registrar. That nurse is fabulous; where does she work? How can I get one of those?" And they become strong proponents of the nurse practitioner (NCNZ[1], p. 23 - 24).*

Another strategy is to expose junior doctors to nurse practitioner capacity:

> *I guess one of the examples was, somebody was out with a student and they were working with them at masters on one of the assessment papers, and they were going through the history and diagnostic reasoning and trying to determine a differential diagnosis. And they were sitting in a ward setting with the case notes having this discussion and the house surgeon was there and they were looking at the diagnostics and the*

> *interpretations of them. And the house surgeon said, "I had no idea you guys did this sort of stuff. This is what we do and its wonderful practice for us as well. Can I join you for the next one?" So that to me said it all (Nurse academic, p. 13).*

So far, the various texts examined in this part of the thesis, have addressed the 'official' and public discourse of physicians and their opposition to nurse practitioner autonomy. Generally absent from publications such as *NZ Doctor* and the *New Zealand Medical Journal* has been the private discourse of doctors who do support nurse practitioners, but have felt constrained by their professional organisations to say so. A number of study participants referred to individual doctors who had personal experience of a nurse practitioner or perhaps a nurse completing his or her prescribing practicum:

> *Doctors at the coalface – we've got at least 20, 25 nurses gone through their nurse prescribing and they have to go and work with a mentor – have been fantastic. And the feedback we get from them [the doctors] is fantastic. They think the nurses are stunning, they're so well prepared; they trust them … But when you go nationally, there's this huge fear and anxiety, there's a lack of understanding of the education programme these students do go through, there's a lack of understanding of the extent of their clinical skills practice (NCNZ [3], p. 2)* .

Luxon (2004) suggests Foucault's work on disciplinary practices created a heritage of trust as an impossibility; but it seems that when doctors are exposed to nurse practitioners on an individual basis, trust becomes possible – although it is hard won ('they're so well prepared'). And so to a very great extent, despite the professional voice of medicine, a new normalcy that is just beginning to emerge, may turn towards trust; a normalcy devoid of hierarchical relations of domination and surveillance.

A qualitatively different type of health service

The intention of the state in 2001 was to disrupt the monopoly of general practitioners by radically transforming primary health care services via the implementation of the PHC Strategy. An ambitious objective, the vision was for a

different type of health service that produced more equitable and long term health outcomes and in more cost efficient ways by utilising the workforce more appropriately. In a sense, the Strategy is political fiat, although might be better understood as an expression of the rationality of current governmental ambitions, via policy. At any rate, it provides an appropriate technical means (Lemke, 2000) to effect improved access to health care, particularly for under-served population groups. However, as Foucault points out, the law can be an ineffective tactic when imposed on individuals and 'a range of multiform tactics' may be better employed (Foucault, 1991b).

One such tactic employed by nursing leaders was to dovetail or 'piggy-back' on the vision of the PHC Strategy and its underlying agenda and to develop an advanced nursing role:

> *None of us ever had in our heads that nurse practitioners would simply be a cheaper way of doing the same thing: none whatsoever. They're an entirely, to me anyway, different, much qualitatively different type of service for people. I think that we did manage to get where we got because of some misconceptions around what a nurse practitioner was. I think we have continued to sustain that drive by piggy-backing on the clear impending disappearance of general practitioners. You know I think in twenty years we may not really have any general practitioners if you look at the demographics (the College, p. 9).*

The speaker in this text is suggesting that the substitution of general practitioners with nurse practitioners may have been perceived by policy makers, at one time, as an attractive idea because of potential cost savings. This misunderstanding or 'misconception' of the contribution NPs would make, initially served to further the nurse practitioner project, via political sponsorship. More recently, alarm has been raised by the Royal New Zealand College of General Practitioners in a series of reports (2005, December; 2006, March; 2006, June; 2006, July) concerning workforce capacity and future workforce intentions of general practitioners. The reports suggested considerable disenchantment with the small business model of general practice. Up to 30 percent of GPs surveyed indicated their intention to reduce work hours, sub-specialise, or leave general practice completely and that

20 percent of GPs were "considering retirement" (RNZCGP, 2006, March, p. 6). It is these 'demographics' to which the speaker (above) refers as the possibility of general practitioners 'disappearing' from their current dominant role in primary health care. In the meantime, the workforce capacity of nurse practitioners is slowly being developed and the role embedded into existing services. The nursing vision was that as NP numbers increase, a qualitative shift in type of health service would emerge, necessitating authentic teamwork relationships between health professionals to ensure the most appropriately prepared practitioner utilises their expertise to meet the particular needs of patients.

However, the limitations of the private GP practice model on full PHC, discussed in chapter eight, prevail and demonstrate the law (the Strategy) has unintentionally engendered an expression of PHC that is constrained by business and bio-medical discourses, assuming considerable dominance in general health care discourse. These ideas are expressed in the following interview excerpt:

> *We seem to concentrate on the general practice model, but the general practice model is limited, its limited and its taken the foreground for primary care. It's not full primary health, it's certainly not population focused (MOH, p. 5).*

The particular form of rationality arising from discourses of ownership and bio-medicine has inscribed itself in a system of practices (Foucault, 1991d) that has produced the "sick-shop" model of general practice (Murdoch & Gurr, 1987) becoming the central focus of the Ministry of Health's efforts to implement the PHC Strategy. The term sick-shop positions individuals who are seeking medical advice as unwell and general practitioners as proprietors of the shop which sells cures. Statements made by the Minister of Health suggest a recent turn in the tide of discourse concerning the sick-shop position. He is reported on the one hand as saying: "We're very clear that GPs are the centre of primary health care" (Hodgson in Cameron, 2006); yet on the other hand, in a speech to the Dunedin School of Medicine, he identifies a future where

> …. we are more and more likely to see nurse-led services for the management of especially chronic disease. Nurse practitioners, of whom we currently have only a few, are likely to replace GPs to an extent as a

> point of first contact and GPs are more and more likely to specialise in complex health problems (Hodgson, 2006, July 21, para. 47).

Three public responses to the Minister's Dunedin speech followed, each informed by different discourses and positioning nursing in different ways: The NZNO informed by an industrial discourse stated, "the plan, which relied heavily on nurses, would fail unless they were paid the same as their hospital counterparts" ("Nurses may replace GPs as point of first contact," 2006); the College of Nurses informed by an academic discourse strongly agreed with the Minister, citing evidence "that up to 70% of presentations in general practice do not need to be seen by someone who is trained in medicine" (Carryer, 2006); and speaking from a discourse of ownership, former Professor of General Practice at Otago Medical School, Campbell Murdoch stated that "replacing GPs with nurse practitioners 'is a really dumb idea' that would threaten the doctor/patient relationship and can only be justified by cost" (Cameron, 2006).

Given the ongoing antagonism ownership and medical discourses construct for nurse practitioners and the apparent failure of government techniques to have general practitioner proprietors adjust their conduct to conform to the new PHC regime, I propose a new mode of subjectivity be examined. This new subjectivity positions nurse practitioners outside the general practice model of private business, but alongside general practitioners and other health professionals in a collaborative approach, so that *full* primary health care can be provided. As the following study participant suggests, it is models of service to which attention must now be turned:

> *So service models are what I'm interested in with nurse practitioners. The individuals - we've got enough frameworks around them. We've got to get over the education stuff; we've got to get over who credentials them and get into looking at the models of service (MOH, p. 7).*

The remainder of this section draws on another excerpt from the email discussion group contribution cited earlier and written by child-youth nurse practitioner, Paula Renouf. It describes a new and invigorating subjectivity created by a non-competitive working environment:

> I have just had a wonderful year and a half working as a child and youth NP in a large busy primary care practice in South Auckland. Here's how it worked in a nutshell: a great experience (clinically). **The GPs**, CHWs, [child health workers] nurses and families can all see the benefits of my role/paradigm of practice, combo of solid primary care medicine with all the NP extras! **Dx [diagnostic] testing?** No problem. **Prescribing?** Not an issue except for dealing with delay in independent access to full formulary – February 06. **Relationship with community pharmacists/hospital consultants for admissions?** Dynamic, helpful and fun. **Competition with GPs?** Not even a concept in anyone's mind and I certainly have great respect for these superb GPs' skills and training medically … **Families thinking they are getting a 'less qualified' practitioner?** Not an issue, they love someone whose fundamental philosophy is to empower and strengthen, get them to find the solutions etc. but who can independently manage their conditions too. **Teamwork with medical staff?** Superb, regular peer group meetings, bidirectional referring/easy consultation. **Teamwork with practice nurses?** Good too (our roles are like the GP/NP role, complementary, a lot of cross over, but different) (July, 2006).

A sense of freedom is conveyed by this description of practice and the working relationships Paula has with colleagues and families (e.g. wonderful, great, dynamic, fun, love, empower, superb). She lists the contentious issues often encountered by nurse practitioners (highlighted in bold), addressing them in turn and seems delighted to report she has not experienced difficulty in these areas. Importantly, Paula's place of work is not an IPA-based practice, but an iwi-based provider, operating on a not-for-profit basis and servicing the health needs of a 'maximally deprived' population. In this environment, Paula is positioned as a valued team member offering a paradigm of practice that is fundamentally empowering to clients and families. Clearly Paula's practice pushes the boundaries of both nursing and medical discourses as she is legally empowered to engage in practices that are outside the normal purview of a nurse. The possibilities presented by this working environment enables Paula to contribute to the body of knowledge about what can be achieved with *most* expert nursing

knowledge and intervention in New Zealand. The organisation Paula works for belongs to what is known as a 'third-sector' primary care organisation; the types of organisation the PHC Strategy (2001) was originally modeled on and they are examined next.

Working in Trust(s)

The third-sector is a term introduced in chapter four in the context of the neoliberal health reforms of the 1990s. It is used to describe primary care organisations tending to serve vulnerable populations and are both non-government and non-profit (Crampton, Dowell, & Bowers, 2000). Third-sector emphasis is on social rather than commercial objectives; the community is involved in management and governance structures; and the health professionals employed are salaried (Crampton, 1999). These three characteristics are not typical of owner-operator type general practices, but both types of general practice may choose to belong to an umbrella Primary Health Organisation. As community trusts, PHOs are not-for-profit entities and are funded by a capitation system based on the number and ethnicity of people enrolled with general practitioners, who are members of a PHO. The importance of capitation funding to nurses and nurse practitioners is:

> the incentive for providers to use health professionals in different, more appropriate ways, as funding is not contingent upon doctors carrying out particular tasks. One effect of this incentive is the expansion of the traditional practice nurse role into the realms of the more challenging nurse practitioner role[83] (Crampton, 1999, p. 22).

However, as explained in chapter eight, two distinctly different types of PHO have developed: the Independent Practitioner Association focused PHOs and the community focused third-sector PHOs. Each brings particular discursive practices arising from their respective history which in turn, shapes the possibilities for nurse practitioners in different ways. It is the practices arising from third-sector-type general practice that form the basis of discussion in this section.

[83] This report was written prior to a formal announcement of nurse practitioner registration in New Zealand, but subsequent to their recommendation in the Ministerial Taskforce on Nursing (1998). There is an explanatory note later in Crampton's report stating: "Nurse practitioner refers to nurses who control nursing services and are responsible for independent case loads" (p. 24).

The following excerpt of text is from a letter to the editor of *NZ Doctor* written by a general practitioner employed by a third-sector practice:

> I am a salaried employee of my workplace, along with 30 other staff from varied disciplines. The practice is an incorporated society and the community owns it. I like this way of working. It means I do not have as much autonomy as I would in my own small business, but my patients are given more ability to determine their own pathway to health. I do not carry the business risk. Neither do I profit from it. I do not have an incentive to push as many patients as possible through the door, so I can give time to those who need it. My income is independent of how many patients I see (apart from the obvious need for the practice to be viable). I relate to my workmates as equals not as employer-employee, and I think this is a significant contribution to being able to work as a multidisciplinary team. Teamwork is different when one person holds the ultimate control. I am in no way critical of my medical colleagues in privately owned practice. (I am avoiding the term "private practice", because it has been pointed out to me we are all publicly funded. This is not about where the funding comes from but how decisions are made about its use.) … I do, however, disagree with the opinion that the only way to achieve quality primary care is by strengthening the doctor-centred, privately owned business at the expense of other models of care (Coppell, 2006).

The text excerpt begins with a description of the workplace in which this general practitioner is employed and its characteristics match those of third-sector organisations, as outlined by Crampton (1999). That is, there are a variety of health professionals who are salaried employees, it is owned by the community and, as an incorporated society, may not associate for pecuniary gain (Incorporated Societies Act, 1908). Without personal liability for business profitability, this GP maintains better care is achieved for patients, because firstly there is more time to spend with them and, secondly relationships with colleagues are not hindered by an employer-employee relationship, so teamwork is better. These beliefs are counter-intuitive to the discourse of ownership previously discussed in relation to primary health care practice and represent a shift in medical discourse towards *compliance* with the truth regime of the PHC Strategy.

It is demonstrated in what is described by the Health Workforce Advisory Committee (2005) as the 'new professionalism'.

Relevant to all health professions, new professionalism generally concerns the relationship between medicine and society. It is characterised by: reflective practice, interdependent decision making (including patient empowerment and engagement with colleagues as equals), teamwork, collective learning, responsibility, accountability and engagement. These characteristics are in contrast to 'old professionalism', which refers to mastery of knowledge, unilateral decision processes, (dependent patients and deferential colleagues), autonomy and self-management, individual accountability and detachment (HWAC, 2005). The Health Workforce and Advisory Committee go further to link new professionalism to the popular literature emanating from the ideas of Robert Greenleaf on 'servant' styles of leadership, suggesting such an approach to governance is more likely to be successful in today's environment.

Significantly, as pointed out by Vivienne Coppell in the text above, decisions about the use of public funds is changed when relations of power within an organisation are deliberately arranged to avoid one particular professional group maintaining a dominant role. Power, of course, remains present with new professionalism, but is distributed in less obvious ways and allows for 'spaces' to emerge in which those other to medicine can more fully contribute. Power within this model becomes more fluid, having "multiple and mobile field[s] of force relations", perhaps fleeting, perhaps "never completely stable" (Foucault, 1990, p. 102), but circulating to produce a dynamic and inclusive workplace.

Community trusts similar to Coppell's employ a high ratio of nurses to doctors and nurses work at a more advanced level of practice with their patients. Essentially, spaces emerge for nurses to advance in such environments in ways that may not be so easily achieved in the private business model. Ideologically aligned already with the government's regime of primary health care, there is little need for third-sector organisations to adjust their conduct to match. For reasons such as these, Vivienne Coppell stresses the need to invest in models of care that are 'other' than that created by the dominant discourse of ownership and the

'doctor-centred, privately owned business' model – a model increasingly in need of 'strengthening' because the accumulating data about its long term viability suggests it to be at risk (HWAC, 2005; Minogue & Goodyear-Smith, 2005; RNZCGP, 2005, December; 2006, March; 2006, June; 2006, July).

The potential for nurse practitioners in these environments (and other environments also), however, is limited by funding mechanisms that do not yet exist (New Zealand Institute of Economic Research, 2004). This concern was acknowledged by a politician interviewed for this study when asked what the most significant barriers are for nurse practitioners:

> *Acceptance by employers. There's plenty of them that want to do it [nurses becoming NPs] … The biggest barrier I see is, by DHB's in particular, employing nurse practitioners at a rate of pay and recognition that they deserve (Senior Politician[1], p. 7).*

However, one example of DHB investment is of Northland DHB which has funded five contracts available to nurse practitioners in third-sector Māori provider organisations, at a cost of $500,000. This has led to one nurse practitioner applicant leaving the "financial constraints within general practice" for a Māori provider offering not only an increased income, but greater opportunities in health care and health promotion in an under-served community (Wynyard, 2006).

There remains, still, a lack of structured and coordinated workforce implementation plans for nurse practitioners. A proposal to the Minister of Health by NPAC-NZ to provide funding for the development and establishment of NP positions was made in April 2005. They suggested options ranging from maintaining the status quo (that is, allow the market to determine a place for NPs), through to establishing a nurse practitioner training scheme based on new CTA funding similar to the CTA-funded registrar scheme for doctors (NPAC-NZ, Carryer, & Hughes, 2005, April). In response to NPAC-NZ's proposal, the Nurse Practitioner Employment and Development Working Party was established in August 2005 to "address sustainable employment opportunities for nurse practitioners" (Ministry of Health, 2006, para. 3). Indications from consultation

with the sector by this working party suggest there is keen interest in the role, but that interest is impeded by purchasing, funding, contracting and structural barriers.

In the meantime, until these barriers are addressed, it falls to the health and disability market to determine employment or self employment opportunities and for prospective NPs to pioneer new positions by garnering employer sponsorship, matching their particular area of expertise with health service goals. To that end, NPAC-NZ have established a business case tool-kit to assist in the development of "business cases for service innovation to submit to funders or purchasers" (NPAC-NZ, 2005, p. 3). The language used in the tool-kit deliberately uses service delivery terminology linking to key government health strategy documents and the PHO Performance Management Programme. As the writers of the proposal to the Minister point out, the risks of the market model are that "key Government strategies for reducing inequalities and improving health gains [will be left] to a state of serendipity" (NPAC-NZ et al., 2005, April, p. 2). Equally important, the personal investment by nurses on the nurse practitioner pathway in tertiary education and professional development – undertaken in trust – will be left untapped.

A health agenda: Positioned politically

The final section of this chapter and of the thesis is to consider the shift in how nurses as nurse practitioners are positioned in both leadership and politics in New Zealand. In Foucauldian terms, the characteristic surveillance or gaze of medicine over nursing affairs has begun to diminish as nursing has become increasingly self-governed in terms of regulation and also with regard to practice. There is instead, a reversal, a turning, a conversion of the gaze on to the self to create a disciplined *but not docile* body, one where sovereignty is maintained over oneself (Foucault, 2004). This kind of discipline Foucault explains:

> does not lead to the constitution of oneself as an object of analysis, decipherment, and reflection. It involves, rather, calling for a teleological concentration. It involves the subject looking closely at his own aim. It involves keeping before our eyes, in the clearest way, that towards which we are striving and having, as it were, a clear consciousness of this aim of

> what we must do to achieve it and of the possibility of our achieving it (p.222).

Foucault goes on to suggest this kind of concentration demands one to "clear a space around the self … to think of the aim … the trajectory separating you from that towards which you want to advance" (p. 223). Thinking then of the aim of the nurse practitioner role, one has to consider if it has been to advance the profession or to improve access to health care services. These ideas are debated in the following interview excerpts:

> *And I really did get fixated that it was good patient outcomes. If you get good patient outcomes you get good things happening for the profession as well. So people get all excited and say you mustn't talk about is it good for the profession. But I truly believed it was (NCNZ[3], p. 1).*

This text highlights the tendency of people to take an either/or position on a matter. The speaker acknowledges this polarisation as a difficulty and holds the personal view that both the good of the profession and good patient outcomes are interrelated.

Benefit to nursing aside, however, the following speaker identifies a very clear and singular direction the nurse practitioner role must now take:

> *Because it's about the benefit of the public, it's not about nursing. This is where you've got to move beyond a nursing agenda to a health agenda. This is about access and equity and about providing a service for the public. So what if it's only 3 or 4 hundred nurses in this county? – that's profoundly different for the public who those nurses will interface with. That's why it's a political development issue (MOH, p. 4).*

Yet in tracing a genealogy of the genesis of the nurse practitioner role as this thesis has done, the voices most absent and/or marginalised are those of the public – ironically those most likely to benefit from the role:

> *… one of the things we have never done well is taken the public with us. Midwifery came in because all the politicians were lined up at the right time, they'd done their homework and they had mothers marching in the*

> *street demanding the right to have the choice for them as a lead maternity caregiver. We have never taken the public; we don't see public marching in the street for the right for nursing to express its full talent for the benefit of the public. Now that's been our fault. We literally do not explain well to the country what it is that we do and how we can do more for them (Nurse academic, p. 19).*

Indeed, both midwifery and mental health services in New Zealand have formed strong consumer alliances, jointly lobbying for appropriate services reflecting the needs of these communities (Neville, 2004). The difference a *most* expert nursing role can make to health consumers in general, however, has all too often been subsumed in public inter and intra-professional debates about the merits of the role, displaying professional disunity hardly inspiring of public confidence. What must be harnessed for the authority of nurse practitioners to be recognised by the public, is the power that is present in the patient encounter (Fairman, 2003).

With the clear and conscious aim of a 'health agenda' in mind, increasingly nurse practitioners are positioning themselves politically. Considering the principle representation of clinical nurses less than fifty years ago was of a docile and useful workforce, nurse practitioners are now seeded throughout various committees in PHOs, DHBs, Universities and the Ministry of Health influencing policy direction and decision-making processes that impact directly on health outcomes for New Zealanders. NPAC-NZ continues to play an important leadership role:

> *One of the best things that we have at NPAC-NZ … is that we have direct access to the Minister and we meet three times a year with the Minister and that's [the] commitment to the nurse practitioner development (NZNO, p. 18).*

Leaders rising from the nursing ranks into management, policy, regulation or education are not a new phenomenon, but nurses who retain a direct clinical caseload and can speak from an academic discourse, tend to be. The shift in acceptance and expectation of nurses to be positioned politically is enhanced by the competency requirements for nurse practitioner registration, which specifically

demand leadership in policy and practice at local and national levels (see NP competencies in appendix one). As an example of the technologies of the self, the competencies serve to exercise power, guiding the conduct of individuals and groups (Foucault, 1983b) and, in this case, contribute to the space from which the aim of improved health services for New Zealanders, can be achieved.

Summary

A new nursing subjectivity embodied in the nurse practitioner role offers the potential to embrace a more liberating mode of practice than is within the normal purview of a nurse. Going against the convention of rational either/or choices (Young, 1995) of *either* doctor *or* nurse, this new subjectivity can arise not from a fixed understanding of 'essential' identity (Bolatagici, 2004), but a space that is simultaneously alienated and aligned to both medicine and nursing. However, an unwanted focus by medicine on the use of diagnostic and prescribing practices has conferred a limited and undermining representation of NP practice that fails to account for the complex range of knowledge that comprises *most* expert nursing practice.

Resistance to medical constructions of the role has led to the freedom to be positioned as a practitioner of one's own creation and relates also to a shift from medical surveillance over nursing to new techniques of self-governance. Nonetheless, nurse practitioners are subject to rigorous surveillance mechanisms by the Nursing Council, implemented in part to assuage medical concerns about the safety of nurse prescribing. Techniques of the self are deployed to have individuals actively constitute themselves (A. Allen, 2000) as safe prescribers, as collaborative practitioners and as trustworthy colleagues. As an 'art' of government (Burchell, 1993), nurse practitioners are conducted towards constructing themselves as valuable contributors to a health service that can produce more equitable and long term health outcomes.

Environments most conducive to a qualitatively different health service are those in which elements of 'new professionalism' predominate such as third-sector organisations. The implications of a dwindling general practitioner workforce necessitate a new normalcy of collegial trust arising, not only from the

impracticalities of medical surveillance of nursing work, but from respect for nurse practitioner capacity.

Finally, while clearly contributing to the professionalisation of nursing, providing an equitable and accessible service to the public is the unequivocal aim of the nurse practitioner role. The positioning of nurse practitioners in leadership and advocacy roles locates expert clinical nurses within health agenda politics at both the source of resource allocation and policy development affecting the health of New Zealanders. As a new mode of subjectivity, the nurse practitioner identity is not defined by the truth claims of others – as nursing has (Papps, 1997) – but by a *nursing* discourse and *nursing* practices informed by multiple forms of knowledge, only one of which is medicine.

Chapter 11: Conclusions

Introduction

Clearly evident throughout the thesis has been the interconnectedness of nursing issues with nurse practitioner issues. Nurse practitioners are regulated by a statutory body comprised of *nurses* and so it is nurses who set the boundaries of nurse practitioner practice, approve programmes for nurse practitioner education and are the final arbiters of safety to practice; it is nurses who become nurse practitioners. The introduction of a nurse practitioner role has had profound effects on the whole of nursing and so this final chapter is important for the nursing profession as a whole.

Asserting a new nursing subjectivity is not a singular event. According to bell hooks (1990), such acts of resistance are not enough; and she suggests the vacant spaces created by resistance are sites of transformation where it is necessary "to become – to make oneself anew" (p. 15). The nurse practitioner role is changing the subject position of nurs*ing,* but as an ongoing process of resistance requires a change in subject position of nurs*es*. This is not to suggest that all nurses will become nurse practitioners, but rather, to point out that nursing in New Zealand has changed irrevocably as a result of the nurse practitioner polemic, contesting the discourses that have constructed nursing for over a century.

What follows is a discussion that highlights the possibilities presented in this thesis to make use of the vacant space that follows resistance (hooks, 1990) and to 'change the subject'; firstly for the image of the nursing profession and secondly, for the nurse practitioner role. Suggestions for further research arising from the limits of this study are proposed, and finally some recommendations, directed not only at challenging what *is* (Foucault, 1991d), but reinforcing what nursing has become.

Changing the subject

Repositioning nursing

A profound shift in possibility for nurses has taken place in New Zealand in the relatively short time of just over a decade. What can be described as a highly successful political endeavour involving multiple players and multiple organisations, has served to disrupt nursing and medical discourses about what nurses and nursing can do. Against unrelenting medical and bureaucratic resistance involving a range of techniques that included force, nurses have played an effective strategic game and made impressive gains for nursing and in consequence, the public of New Zealand. The introduction of practices of assessment, diagnosis and the prescription of treatment, challenged "the limits and forms of the *sayable*" (Foucault, 1991c, p. 59) previously available within a general nursing discourse. The possibilities presented by the availability of these practices positioned nurses as independent from medicine. Considering the original place of nursing in relation to medicine, the articulation of an independent and *most* expert nursing subjectivity was a revolutionary alternative to traditional methods of health care provision.

The change in image brought about by these practices applies not only to nurse practitioners, but has repositioned nursing generally. Practices of assessment and diagnosis, and knowledge of pharmacology are available to all nurses who undertake clinical master's level courses. Whether intending to apply to the Nursing Council to become a nurse practitioner or not, these nurses practice differently as they make use of new-found knowledge and skills in their day to day work with clients. Thus ever so slowly, a change in nursing subjectivity has begun to establish a new norm by 'raising the bar' for all nurses, and particularly so as undergraduate nursing curricula also emphasise assessment skills and pharmacology.

Illustrating the shift of these practices into everyday nursing discourse is the current review of the Medicines (Standing orders) Regulations, 2002. A problem has arisen because nurses 'creatively interpret' the regulations to improve service delivery but are doing so in non-emergency situations, thereby exposing

themselves and the countersigning medical practitioner to legal risk. A potential solution is to consider “whether alternative ways of allowing nurses to prescribe should be looked at” ("Health professionals push limits," 2007, p. 3). It seems extraordinary that only eighteen months has elapsed since the regulations for nurse practitioner prescribing were passed, and already the image of nursing has changed sufficiently for registered nurse prescribing to be seriously considered. The Minister of Health has endorsed this position at the inaugural conference of nurse practitioners in Dunedin:

> That is why we are also looking at the proposal to extend prescribing rights to nurse specialists … By extending prescribing rights to nurse specialists, of whom there are hundreds, we would be encouraging more flexible and efficient ways of delivering health services (Hodgson, 2006, November 29, para. 7 - 8).

This text illustrates that simply talking about nursing differently disrupts historical discourses of the docile and useful nurse, and the continual association of assessment, diagnostic and prescribing practices with nurses is serving to establish a new norm for nursing practice.

Furthermore, the political activism engendered within nursing that developed the nurse practitioner role, has also served to project nurses into the political system of health planning, positioning nursing beyond traditionally accepted boundary roles. Where once only medical practitioners and perhaps the Director, Division of Nursing would be consulted in health service planning, as of right, nurses from all levels in clinical, education and research areas are now called upon to contribute to discussion documents, reference groups and various health committees to advise the Ministry of Health and in due course, the Minister. Thus nurses who gain a sense of the possibilities and potential that lies within the political system are shifting the image of nurses from that of usefulness *only* in workforce terms, to one of leadership in health-related matters.

In contrast to a preoccupation of service to the medical profession, the introduction of the nurse practitioner role has brought a renewed focus to the *population* nursing serves. While there is much work yet to be done to transform

the image of nurses to one of equal professional contribution in the eyes of medicine, bureaucrats, nurses themselves, and the public, the teleology of all nursing endeavour is assuredly, population health and well-being. Although a joint interest with medicine, the overriding concern is no longer to endorse medical interests, but to improve access to health services by ensuring the most appropriately prepared professional is empowered to provide complete episodes of care.

Unlike the public support midwifery garnered from a well-informed and motivated parent population, 'selling' the nurse practitioner role to a public that was largely uninformed about the contribution of advanced nursing, stems from the invisibility of nursing work and the difficulties nurses have describing their work (Buresh & Gordon, 1995a, 1995b). Thus without manifest consumer support, the nurse practitioner initiative to improve consumer access to health services was driven by a dedicated nursing leadership whose aspirations were in accord with the current regime and policy agenda of the Minister of Health (if not always the *Ministry* of Health). It could be argued that the failure to engage the public in the debate was a strategic oversight, but as occurred in the UK, even with strong consumer alliances, securing legal provisions for nurse prescribing took the better part of a decade and still required "deft manoevering within the corridors of power" (Mark Jones, 2004, p. 173).

Bringing about a shift in discourse can be secured more readily when there are alliances across a range of interest groups. Cohesion amongst the primary group seeking the change is also vital. Within a discipline as large as nursing, there will inevitably be competing discourses that position nursing as internally divided. While contained within nursing, these tensions can be generative and ultimately collaborative, but when aired outside of nursing the image of a unified profession is readily destroyed. The ever present temptation to retreat to the either/or position of competing discourses tends to preclude the possibility that even contradictory discourses can be ascribed to simultaneously. To include opportunities that arise from working in wider collectives (particularly consumer groups), recognises the inherent power working alongside communities of interest generates; speaking less *for* others and more *with* others (Foucault in Luxon, 2004).

Everything is dangerous: Vigilance

Conceiving of nurse practitioners not as docile bodies lacking in agency, but as "reflexive, living, speaking beings" suggests "a more active notion of subjectivity," and implies a rich capacity to resist (N. J. Fox, 1997, p. 41). Working against such an active interpretation of the nurse practitioner's subjectivity is the notion of practice protocols for nurse practitioners. These are a new development and can be read as a potentially dangerous manifestation of a medical discourse reasserting the right to ownership of nursing practice.

Practice protocols are intended to direct the clinical responses of NPs in the management of patients presenting with particular illness events or trajectories (Carryer, Gardner, Dunn, & Gardner, 2007). Not necessarily innately 'bad', practice protocols should, however, at least be considered a 'dangerous' attempt (Foucault, 1983a) to normalise the practice of nurse practitioners. Carryer et al. stress that protocols are distinct from clinical guidelines: protocols infer a requirement for rigid adherence; whereas clinical guidelines are a compilation of graded evidence used across the disciplines to *support* practice. Imposed in some areas of Australia, sometimes at regulatory level and others at employer level, practice protocols designed for nurse practitioners undermine autonomy by mandating particular procedures, even nominating when to refer a client to a medical practitioner.

Protocols are approved by a range of health professionals in education, senior clinical nursing roles, and by doctors. As Carryer et al. (2007) observe, at first glance, the rationality underlying protocols is to ensure safe and cautious practice, but on a more covert and disquieting level, they have a special kind of strategical directedness (Dreyfus & Rabinow, 1983) that extends medical control over nursing practice. In short, the protocol becomes the doctor in absentia.

In Foucaldian terms, protocols are a mechanism to establish what is normal in advance, "and then proceed to isolate and deal with anomalies given that definition" (Dreyfus & Rabinow, 1983, p. 258). Deviation from the protocol to address the individual needs of a client brings "into play the binary opposition of the permitted and the forbidden" (Foucault, 1977a, p. 183). Justification for the

deviant clinical response is then necessary, implying somehow a transgression has taken place, and not merely the application of creative clinical judgment tailored to client need.

So much potential is lost when expert practice is contained by protocol. The standardisation of processes leads to a homogenous level of care that is entirely predictable. Carryer et al. (2007) suggest it is wasteful and counterproductive to prepare nurses to such an advanced level only to have them constrained by what amounts to a meticulous ritual of power. Predictable care, however, creates certainty; it is measurable and it is quantifiable, but of greater import, it contains the nurse practitioner workforce into predictable and known capability. Here again, the mechanism for control is for a unified identity of nurse practitioner with clearly drawn boundaries of practice jurisdiction. Remaining vigilant about this potential constraint on *most* expert nursing practice in New Zealand will be necessary.

However, a clearly bounded type of practitioner, the physician assistant, may soon be available to fill the interstice this thesis has been at pains to trace. At the risk of awarding the role undue importance, it is a development on which a watchful eye should be kept. Despite argument questioning the need for nurse practitioner 'physician substitutes' in New Zealand, recent discussions about the possibility of a physician assistant role have arisen (Gorman & Scott, 2005, 2006; Johnston, 2005; van der Stoep, 2006). There are similarities and cross-over between nurse practitioner and physician assistant roles, but unlike NPs, physician assistants emphasise *medical* rather than *health* care (College of Nurses Aotearoa, 2005, August; 2006, November). Importantly, physician assistants work under a supervising physician whereas nurse practitioners work independently. Again not necessarily 'bad', physician assistants are a reinvention of a body of helpers that are both docile and useful to medicine, and may even serve to free nurses from being so positioned. Having unsuccessfully contested nurse practitioner independence in New Zealand, the introduction of a role that can be legitimately controlled by medicine resurfaces notions embedded within medical discourse – those of a directable and supervised subordinate.

Limitations and possibilities for further research

Within a New Zealand political and social context the intention of this thesis has been to foreground the discourses that have constructed the nurse practitioner role. As stated from the outset, an interpretation or version of the truth is offered in this study that is partial (Wetherell et al., 2001a). As an incomplete account, there are ample possibilities for further research and some suggestions follow.

The clinically focused master's degree curricula and the extent to which it challenges existing discourses about nurses and nursing, and equips nurses for *most* expert nurse practitioner roles deserves research attention. Spence and Anderson (2006) have recently completed a pilot study of the prescribing practicum offered in two New Zealand tertiary institutions, but recommend an extended project, that among other things, would evaluate client outcomes. However, of the projects related to nurse practitioners catalogued by NPAC-NZ and hosted on the Ministry of Health website, only one single-site aged-care client outcomes study is listed as in progress by Deborah Gillon. Given the missing text throughout this thesis has been that of the consumer, it seems imperative that further research to evaluate the difference *most* expert nursing practice makes to consumers, is initiated.

Another avenue for further research, arising as a subtext to this study, is that of nursing leadership. As has been mentioned, a concentration of power occurred as an effect of individuals holding office across a number of closely related institutions, facilitating the dominance of particular discourses within the nursing profession. Because Foucault was not especially interested in *who* has power (Sarup, 1996), but rather, in the production of discourses and their power effects, this study does not focus on the key individuals who worked tirelessly to bring the nurse practitioner role to fruition. Susan Jacobs (2005) refers to these nursing leaders as 'policy entrepreneurs' and while her thesis showcases many of these women, much of the strategic game playing over the Medicines (Designated Prescriber: Nurse Practitioners) Regulations, 2005 occurred following completion of her project. What is more, presenting new obstacles for nurse prescribing (Cassie, 2007), the Therapeutic Products and Medicines Bill scheduled to replace

the Medicines Act, 1981, is before parliament in 2007. As the Bill progresses through the House, adroit leadership continues to be necessary in order for nurse practitioners to secure greater independence as authorised prescribers than the current designated status affords. As a domain of nurse practitioner competence, *clinical* nursing leadership too, has been identified by Carryer, Gardner, Dunn and Gardner (2006) as an area of pressing need for further research.

A necessary limitation of this thesis has been the focus on nurse practitioners in the context of primary health care. When this study commenced, an initial intention was to examine advanced rural nursing practice. One interview with a rural nurse academic took place, however; data from that interview has not been used in the study because it soon became apparent that the issue of rural sector nursing merits dedication of a study this size to that topic alone. Furthermore, a master's level project about primary health care roles in rural New Zealand has recently been completed in 2005 by Heather Maw.

Other settings, such as aged care, and palliative and hospice care, are particularly appropriate practice locations for nurse practitioners because these clients require advanced nursing assessment and the timely provision of care compatible with a nursing philosophy that makes the most of life. As chronically under-funded services, aged care and palliative care need the cost-effective solutions achieved when a complete episode of care is provided by a single practitioner. At present there is a nurse practitioner working in each of these areas in New Zealand but although specialist palliative/hospice care is provided by third-sector organisations, their isolation from mainstream health services has reinforced traditional doctor-nurse roles, limiting possibilities for nurses to advance. Further research should not be confined only to these settings, however, as there are few areas of practice in which it would be inappropriate for nurse practitioners to work.

With respect to Foucault

Not power, but the subject has been the general theme of Foucault's work. The question of power relates to understanding how we have been trapped in our own history not so much by one particular group or institution, but rather by a

technique, a form of power (Foucault, 1983b). Imposing a law of truth, these techniques of power both subjugate and make subject, and it is these effects of power that nursing has, and continues to struggle to break free from. It is with respect to these basic premises of Foucault's theorising that I have sought to produce an authentic representation of the nurse practitioner polemic, as it has so far developed in New Zealand.

Foucault described his work as being intentionally irritating to people because rather than propose a new and/or validating schema, he raises problems for the subject who must then act (Foucault, 1991d). This call to action, this work on the self is not a task for docile bodies, but a new ontology involved in the interpretation and rewriting of discourse and, therefore, one's own subjectivity (N. J. Fox, 1997). Perhaps somewhat esoteric to some, Foucault's interest lay in the real effects discourses produce. Rewriting a nursing discourse seems a necessary endeavour, and the following recommendations to achieve that end (if an end is indeed possible) arise from the data analysis presented in this study.

Rewriting discourse

The penultimate section to this thesis then concerns 'what is to be done', but as cautioned by Foucault, ought not to be determined from on high in prophetic or legislative terms, but "by a long work of comings and goings, of exchanges, reflections, trials and different analyses" (Foucault, 1991d, p. 84). By this he means it is not just a case of declaring something to be so, or by changing the law, but by challenging the micro-practices that contribute to the ways people perceive and do things. He goes on to state:

> Critique doesn't have to be the premise of a deduction which concludes: this then is what needs to be done. It should be an instrument for those who fight, those who resist and refuse what is. Its use should be in processes of conflict and confrontation, essays in refusal. It doesn't have to lay down the law for the law. It isn't a stage in programming. It is a challenge directed to what is (Foucault, 1991d, p. 84).

The challenge is to continue to refuse and to resist historical representations of nursing as the norm. The productive power of discourse has meant that talking

about nursing differently has rewritten nursing discourse sufficiently for nurses to begin to imagine how their practice *might be*. The real effect a shift in nursing discourse has produced is that now there is the freedom for nurses to make their imaginings so if they choose. The choice for a nurse may lie in becoming a nurse practitioner, but could simply mean the ability to engage in nursing practice differently. Not all 44,442 or so registered nurses in New Zealand will find this an attractive idea, but for the many thousands of nurses who do, there will be a profound impact on the members of the public with whom they interface, and who will benefit from greater nursing expertise.

Another challenge is to rewrite the discourse that presents nursing as a divided body. There are natural divisions within nursing but these have served in the past to unhelpfully position nursing in either/or polarities. A transformative shift is needed away from a *nursing* agenda towards a *health* agenda. Central to notions of advanced nursing practice is the benefit to the public health, and while there may be associated changes in status for the nurses who so engage, that is not the overriding concern. By engaging with consumers, nurses can engage with authenticity in the political processes that govern health service delivery. With a health agenda in mind, the potential of advanced nursing practice can be best realised in the practice locations that already value nursing expertise.

Foucault (1991d) advises critiques such as this thesis serve as essays in refusal. The proclivity of physicians to remain in a surveillance role over nursing practice *requires nurses to act*, and must be continued as an essay in refusal by nurses and nursing. The comfort derived by the assurance of medical accountability is insufficient justification for the controlling practices medicine engages in; vigilance is needed to guard against new interpretations of medical authority over nursing practice.

Concluding statement

The contribution this thesis makes is to document the discourses that have contributed to the revolution of the New Zealand nursing identity. Through a kind of regulated freedom, the nurse practitioner polemic has created an interstice from which all nurses are free to constitute themselves as autonomous practitioners,

beyond the truth claims of medicine or even conventional nursing subjectivities – if they so choose. Producing nurses as automatons necessitates mechanisms of surveillance and control, against which resistance is inevitable. Educating nurses for autonomy within relations of mutual trust, however (Luxon, 2004), forestalls the tension brought about by control. By changing the nursing subject so, the hope is for a qualitatively different health service that is, indeed, surprising.

Appendices

The following pages include the nurse practitioner competencies (NZ Nursing Council, 2004b), and documents relevant to the Massey University Human Ethics Committee approval for this research.

Nurse Practitioner Competencies (Appendix one)

Massey University Human Ethics Committee Letter of Approval (Appendix two)

Information Sheet for Study Participants (Appendix three)

Consent Form (Appendix four)

Nurse Practitioner Competencies

1. Articulates scope of nursing practice and its advancement

The nurse practitioner is able to:

- define the scope of independent/collaborative nursing practice in health promotion, maintenance and restoration of health, preventative care, rehabilitation and/or palliative care
- describe diagnostic inquiry processes respond to actual and potential health need and characteristics of the particular population group
- explain the application/adaptation of advanced nursing knowledge, expertise and evidence based care to improve the health outcomes for clients across the care continuum within the scope of practice
- generate new approaches to the extension of nursing knowledge and delivery of expert care with the client groups in different settings.

2. Shows expert practice working collaboratively across settings and within interdisciplinary environments

The nurse practitioner:

- demonstrates culturally safe practice
- uses professional judgement to:
- assess the client's health status
- make differential diagnoses/implement nursing interventions /treatments
- refer the client to other health professionals
- develops a creative, innovative approach to client care and nursing practice
- manages complex situations
- rapidly anticipates situations
- models expert skills within the clinical practice area
- applies critical reasoning to nursing practice issues/decisions
- recognises limits to own practice and consults appropriately, facilitating the client's access to appropriate interventions and/or therapies
- uses and interprets laboratory and diagnostic tests

- operates within a framework of current best practice and applies knowledge of pathophysiology, pharmacology, pharmokinetics and pharmacodynamics to nursing practice assessment/decisions and interventions
- accurately documents and administers assessments, diagnosis, intervention, treatments and follow-up within legislation, codes and scope of practice
- evaluates the effectiveness of the clients response to prescribed interventions, appliances, treatments and medications and monitors decisions, taking remedial action and/or referring accordingly
- collaborates and consults with the client, family and other health professionals providing accurate information about relevant interventions, appliances and treatments.

3. Shows effective nursing leadership and consultancy

The nurse practitioner:

- takes a leadership role in complex situations across settings and disciplines
- demonstrates skilled mentoring/coaching and teaching
- leads case review and debriefing activities
- initiates change and responds proactively to changing systems
- is an effective nursing resource
- participates in professional supervision.

4. Develops and influences health/socio-economic policies and practice at a local and national level.

The nurse practitioner:

- contributes to and participates in national and local health/socioeconomic policy
- demonstrates commitment to quality, risk management and resource utilisation
- challenges and develops clinical standards plans and facilitates audit processes
- evaluates health outcomes and in response helps to shape policy.

5. ***Shows scholarly research inquiry into nursing practice***

The nurse practitioner:

- evaluates health outcomes, and in response helps to shape nursing practice
- determines evidence-based practice through scholarship and practice
- reflects and critiques the practice of self and others
- influences purchasing and allocation through utilising evidence-based research findings.

6. ***Prescribes interventions, appliances, treatments and authorised medicines within the scope of practice***

The nurse practitioner seeking prescribing rights:

- uses professional judgement to prescribe
- collaborates and consults with, and provides accurate information to, the client, the client's family and other health professionals about prescribing relevant interventions, appliances, treatments or medications
- prescribes and administers medications within legislation, codes, scope of practice and according to the established prescribing process and guidelines
- understands the use, implications, contra-indications, and interactions of prescription medications with each other and with alternative/traditional/ complementary medicine and over-the-counter medications/appliances
- understands the age-related implications of prescriptive practice on clients within the specific area of practice
- evaluates the effectiveness of the client's response to prescribed medications, and monitors decisions about prescribing, taking remedial action and/or referring accordingly
- demonstrates an ability to limit and manage adverse reactions/emergencies/crises
- recognises situations of drug misuse and acts appropriately
- understands the regulatory framework associated with prescribing, including the legislation, contractual environment, subsidies, professional ethics, and roles of key government agencies.

Massey Human Ethics Committee: Wellington

11 March 2004

Jill Wilkinson
19 Izard Road
Khandallah
WELLINGTON

Dear Jill

Re: MUHEC: WGTN Protocol - 03/147
A discourse analysis of the Nurse Practitioner role in the New Zealand context

Thank you for your email of 9 March 2004 with your reply to the questions and comments raised by the Massey University Wellington Human Ethics Committee.

Your application now meets the requirements of the Massey University Human Ethics Committee and the ethics of your protocol are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, a new application must be submitted at that time.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

A reminder to include the following statement on all public documents: "This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN Protocol 03/147. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Wellington Human Ethics Committee, telephone 04 801 2794 ext 6358, email J.J.Hubbard@massey.ac.nz.

Yours sincerely

Jeremy Hubbard (Acting Chair)
Massey University Human Ethics Committee: Wellington

Cc: Professor Annette Huntington, College of Humanities & Social Sciences
Dr Jean Gilmour, College of Humanities & Social Sciences

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Information Sheet for Study Participants

A discourse analysis of the Nurse Practitioner role in the New Zealand context: PhD Thesis Research

The newly established role of Nurse Practitioner (NP) in New Zealand signals a significant change of ideology in both nursing and the state over the last five years. The emergence of the Primary Health Care Strategy (2001) and the centrality of NP's to successful implementation of the strategy reflect this change in orientation. The prevailing discourses of the time such as those of nurse leaders, agents of the state, and of medicine are worthy of examination. It is the intention of this thesis to analyse the development of the Nurse Practitioner role within the historical, and foreseeable future political and social institutional opportunities and constraints.

A vital aspect of my research is to talk with people who have an interest in the Nurse Practitioner role, and to represent their views about the ways it developed and will continue to develop. The way in which the role is both facilitated and hindered is of particular interest to this study. My intention is to focus on a group not larger than twenty people who have been involved in the debate about the establishment of the NP role, and to seek their assistance by asking them to share their ideas with me.

An Invitation

You have been identified by your role, and possibly your published writing about the development of the NP role in New Zealand. You are invited to participate in this study by agreeing to be interviewed by the researcher about your involvement and ideas.

- Your involvement in the research will require a commitment to an hour-long interview and will be conducted at a mutually agreeable time and private venue.

- With your permission, I would like to audio tape the interview and have the tape transcribed by a typist who will sign a declaration of confidentiality.

- I will send a transcript of the interview back to you for confirmation, or to enable you to make any changes. You have the right to delete any parts of the transcript, and to withdraw from the study at any time until you return the transcript to me for data analysis.

- I will ask that you return the transcript to me within a month of receiving it. The data will be used for my thesis, and for any publication or presentation that may arise in association with this study.

- The audio tape and transcript will be stored in a locked filing cabinet and your name changed to an agreed pseudonym. They will be kept separate from consent forms. Your place of employment and role will be referred to in the study by an agreed generic title.

- At the completion of the study I will return the audio tape and transcript to you, or alternatively I will destroy the tape and transcript after five years (requirement for auditing purposes).

You have the right

- to decline to participate
- to refuse to answer any particular questions
- to withdraw from the study up until the time the transcript is returned to me following the interview
- to ask any questions about the study at any time during participation
- to provide information on the understanding that your name will not be used unless you give permission for your name to be used
- to be given access to the summary of the findings of the study when it is concluded
- to ask for the audio tape to be turned off at any time during the interview.

Potential risks and benefits from participation

Benefits from your participation are the opportunity to talk about and reflect on the NP role, and the direction you see the role taking in the future. You will also contribute to research that describes, explores and analyses a significant period in New Zealand nursing history. Due to the relative newness of the NP role, it is important that not only evaluation research is undertaken, but also research that examines the particular discourses of the time. I will provide you with a summary of the findings when the study is completed. A potential risk of participation is that your contribution and role could be recognised by a reader. I would take every step to minimise this risk, but you need to be aware that this possibility exists. Another potential risk is the cost of your valuable time. I will aim to minimise the cost of your time by traveling to meet you.

I will be contacting you by telephone within the next two weeks to ask whether you consent to participate in the study. Should you wish to ask any questions concerning this research, please do not hesitate to contact my supervisor, or me.

Thank you for taking the time to consider participating.

Researcher
Jill Wilkinson, RN
Phone 04 973 7853
jill.wilkinson@paradise.net.nz

Supervisor
Associate Prof Annette Huntington
School of Health Sciences
Massey University, Wellington
Phone 04 801 2794 Ext. 6315

This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN Protocol 03/147. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Wellington Human Ethics Committee, telephone 04 801 2794 ext 6358, email J.J.Hubbard@massey.ac.nz.

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A discourse analysis of the Nurse Practitioner role in the New Zealand context: PhD Thesis Research

Consent Form

This Consent Form Will Be Held for a Period of Five (5) Years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

Please indicate your choice:

- I agree / do not agree to the interview being audio taped. I also understand that I have the right to request the audio tape to be turned off at any time during the interview.
- I wish to have the audio tape and final transcript of the interview returned to me/I consent to disposal of the audio tape and transcripts five years after completion of the research.
- I agree to participate in this study under the conditions set out in the information sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. Chicago: University of Chicago Press.

Adams, A., Pelletier, D., Duffield, C., Nacy, S., Crisp, J., & Mitten-Lewis, S. (1997). Determining and discerning expert practice: A review of the literature. *Clinical Nurse Specialist, 11*(5), 217 - 222.

Adams, J. (2002, August 15). *Is that a nurse? [Chairman's editorial]. New Zealand Medical Association*. Retrieved September 2, 2002, from http://www.nzma.org.nz/news/editorial1.html

Adams, K. F. (2003). *A postmodern/poststructural exploration of the discursive formation of professional nursing in NZ, 1840 - 2000.* Unpublished PhD thesis, Victoria University, Wellington. Retrieved June 17, 2004 from http://users.actrix.co.nz/kathryn/index.htm.

Affara, F. (1995). International regulation today. *International Nursing Review, 42*(5), 152 -158.

Affara, F. (2006). *SWOT analysis of advanced nursing practice becoming recognised as a valid part of nursing and health care service provision globally*. Retrieved March 11, 2007, from http://www.aanp.org/NR/rdonlyres/edw7gnx2cgspgvfu6fc23fsp3u456amdanqkeqtde4xg7654qtjkzhzpw7crgr2vsxqsfwkemyjs5vx5lfsediuowsc/SWOTNPAPNJune2006.ppt#256,1,Strengths

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology, 17*, 105- 131.

Agger, B. (1994). Derrida for sociology? A comment on Fuchs and Ward. *American Sociological Review, 59*, 501 - 505.

Ainge, N. (1993). A Cantabrian innovation: The clinical career pathway for nurses. *Nursing Praxis in New Zealand, 8*(3), 11 - 17.

Ajwani, S., Blakely, T., Robson, B., Tobias, M., & Bonne, M. (2003). *Decades of disparity: Ethnic mortality trends in New Zealand, 1980-1999* (No. 16 Occasional Bulletin, Public Health Intelligence). Wellington: Ministry of Health & University of Otago. Retrieved February 10, 2005, from http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/febdcf2d4baae173cc256d5c00137cae/$FILE/EthnicMortalityTrends.pdf.

Allen, A. (2000). The anti-subjective hypothesis: Michel Foucault and the death of the subject. *The Philosophical Forum, XXXI*(2), 113 - 130. Retrieved December, 2004 from http://www.dartmouth.edu/~aallen/papers/philosophical%2020forum.pdf.

Allen, N. R. (Ed.). (1992). *A framework for nursing and midwifery education in New Zealand: A discussion paper prepared for the Vision 2000 Committee*. Auckland: Vision 2000 Committee.

American Medical Association. (2004). *H-360.989 Independent nursing practice models*. Retrieved June 1, 2004, from http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-360.989.HTM

American Medical Association Committee on Nursing. (1970). Medicine and nursing in the 1970's: A position statement. *JAMA, 213*(11), 1881 - 1883.

Anaesthesia not an option for nurse prescribing. (2005). *New Zealand Nursing Review, 6*(6), 2.

Anderson, R. (1971). Ready for battle [Editorial]. *New Zealand Nursing Journal, June*, p. 3.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378 - 395.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online, 1*(1), Retrieved January 9, 2006, from http://extra.shu.ac.uk/daol/previous/v2001_n2001.html.

Arcus, K. (2004). *Often wearisome, sometimes saddening, but always interesting: A hundred years of district nursing in Wellington, 1903-2003.* Unpublished Masters thesis, Victoria University, Wellington, NZ.

Armstrong, D. (1997). Foucault and the sociology of health: A prismatic reading. In A. Petersen & R. Bunton (Eds.), *Foucault: Health and medicine* (pp. 15 - 30). London: Routledge.

Ashton, C. (1990). A competency-based practicing certificate. *New Zealand Nursing Journal, 83*(5), 23.

Ashton, T. (1992). Reform of the health services: Weighing up the costs and benefits. In J. Boston & P. Dalziel (Eds.), *The decent society?: Essays in response to National's economic and social policies* (pp. 146 - 168). Auckland: Oxford University Press.

Audi, R. (Ed.). (1995). *The Cambridge dictionary of philosophy*. Cambridge: Cambridge University Press.

Baer, E. (2003). Philosophical and historical bases of advanced practice nurse roles. In M. Mezey, D. McGivern & E. Sullivan-Marx (Eds.), *Nurse practitioners: Evolution of advanced practice* (4th ed., pp. 37 - 53). New York: Springer.

Baillie, M. (2003). Practice nurse incensed at treatment of rural nurse. *Kai Tiaki Nursing New Zealand, 9*(4), 3 - 4.

Baird, C. W. (1996). *The employment contracts act and unjustifiable dismissal: The economics of an unjust employment tax*. Wellington: New Zealand Business Roundtable & New Zealand Employers Federation. Retrieved December 17, 2004, from http://www.nzbr.org.nz/documents/publications/new-publications/ecaf-cont.doc.htm.

Baker, A. (1992). Setting the rules: Pharmaceutical benefits and the welfare state. In P. Davis (Ed.), *For profit or health? Medicine, the pharmaceutical industry, and the state in New Zealand* (pp. 18- 35). Oxford: Oxford University Press.

Ballou, K. A. (1998). A concept analysis of autonomy. *Journal of Professional Nursing, 14*(2), 102-110.

Barnett, P., & Barnett, R. (1999). Reform and change in health service provision. In K. Dew & P. Davis (Eds.), *Health and society in Aotearoa New Zealand* (pp. 219 - 234). Melbourne: Oxford University Press.

Barnett, R., & Barnett, P. (2004). Back to the future? Reflections on past reforms and future prospects for health services in New Zealand. *GeoJournal, 59*(2), 137 - 147.

Barnett, R., Barnett, P., & Kearns, R. A. (1998). Declining professional dominance?: Trends in the proletarianisation of primary care in New Zealand. *Social Science & Medicine, 46*(2), 193 - 207.

Bazley, M. (1972). Report effects all nurses. *New Zealand Nursing Journal, 65*(5), 4 - 5.

Bazley, M. (1978). Post-basic nursing education in technical institutes. *New Zealand Nursing Journal, 71*(8), 25.

Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (2000). *Nursing research: Methods, critical appraisal and utilisation* (1st Australian ed.). Sydney: Mosby.

Beekman, E., & Patterson, L. (2003). Nurse prescribing in New Zealand: Professional gain or political loss? *Nursing Praxis in New Zealand, 19*(1), 15 - 22.

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

Benner, P. E. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, California: Addison-Wesley.

Benner, P. E., & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness*. Menlo Park, California: Addison-Wesley.

Bexley, M. (1998). Validity of Taskforce Report questioned [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 4*(5), 5.

Bhabha, H. K. (1994). *The location of culture*. London: Routledge.

Bickley-Asher, J. (2005, November 16). Better medical care. *The Press,* p. 19.

Bicknell, J. (1908). Formation of the New Zealand Trained Nurses Association by the amalgamation of the four centres. *Kai Tiaki: The Journal of the Nurses of New Zealand, 2*(3), 82.

Biggs, J. (2000). *Teaching for quality learning at university: What the student does*. Buckingham: Society for Research into Higher Education & Open University Press.

Bissinger, R. L., Allred, C. A., Arford, P. H., & Bellig, L. L. (1997). A cost-effectiveness analysis of neonatal nurse practitioners. *Nursing Economics, 15*(2), 92 - 100.

Blake, N. (1997). Awards on the brink. *Australian Nursing Journal, 5*(3), 19 - 23.

Blanc, A. D. G. (1949). *Money, medicine and the masses*. Wellington: A.H. & A.W. Reed.

Board of Health. (1974). *An improved system of nursing services in New Zealand.* Wellington: Government Print.

Bohm, S. M. (1971). Colleges of Health Sciences. *New Zealand Nursing Journal, 64*(9), 23 - 25.

Boland, C., & Leib, S. (2003). Pediatric nurse practitioner and pediatrician: Collaborative practice. In M. Mezey, D. McGivern & E. Sullivan-Marx (Eds.), *Nurse practitioners: Evolution of advanced practice* (4th ed., pp. 367 - 375). New York: Springer.

Bolatagici, T. (2004). Claiming the (n)either/ (n)or of 'third space': (Re)presenting hybrid identity and the embodiment of mixed race. *Journal of Intercultural Studies, 25*(1), 75 - 85.

Boston, J., & Dalziel, P. (Eds.). (1992). *The decent society?: Essays in response to National's economic and social policies*. Auckland: Oxford University Press.

Boswell, R. (2005a, June 17). NZMA address to GP CME conference in Wairakei, Taupo*,* pp. 1 - 12.

Boswell, R. (2005b). Prescribing nurses [Letter to the editor]. *Nursing Review, 6*(5), 5.

Boyne, R. (1990). *Foucault and Derrida: The other side of reason*. London: Unwin Hyman.

Brash, D. (2005). *What ever happened to personal responsibility? An address by Don Brash, Leader of the National Party to the Orewa Rotary Club on 25 January 2005*. Retrieved January 25, 2005, from http://www.scoop.co.nz/mason/stories/PA0501/S00217.htm

Bringer, J., Johnston, L., & Brakenridge, C. (2004). Maximizing transparency in a doctoral thesis: The complexities of writing about the use of QSR*NVIVO within a grounded theory study. *Qualitative Research, 4*(2), 247 - 265.

Brinkman, A. (2006). Election planning for the next Nursing Council in 2009. *Kai Tiaki Nursing New Zealand, October*, p. 28.

Brown, B. M. (1966). Political parties. In A. H. McLintock (Ed.), *Te Ara - An encyclopaedia of New Zealand*. Retrieved July 22, 2006, from http://www.TeAra.govt.nz/1966/P/PoliticalParties/en.

Brown, C., & Seddon, J. (1996). Nurses, doctors and the body of the patient: Medical dominance revisited. *Nursing Inquiry, 3*, 30 - 35.

Brown, K. (Writer) (2006). Midwives: Insight for 5 February [Audio]. In P. Tolley (Producer): Retrieved February 7, 2006, from http://www.radionz.co.nz/nr/programmes/insight.

Brown, S., & Grimes, D. (1995). A meta-analysis of nurse practitioners and midwives in primary care. *Nursing Research, 44*(6), 332 - 338.

Bukofzer, M. (2005). Are nurse anaesthetists needed? Should the Nursing Council endorse nurse practitioners in anaesthesia? One leading anaesthesia specialist argues against nurse practitioners as providers of anaesthesia services [Viewpoint]. *Kai Tiaki Nursing New Zealand, 11*(3), 19.

Burchell, G. (1993). Liberal government and techniques of self. *Economy and Society, 22*(3), 267 - 285.

Buresh, B., & Gordon, S. (1995a). Nursing in the right words. *American Journal of Nursing, 95*(3), 20 - 21.

Buresh, B., & Gordon, S. (1995b). Tell the world what you do. *American Journal of Nursing, 95*(1), 17 - 18.

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

Burgess, M. E. (2002). *A guide to the law for nurses and midwives* (3rd ed.). Auckland: Pearson Education.

Burman, E. (1991). What discourse is not. *Philosophical Psychology, 4*(3), 325 - 342.

Burman, E., & Parker, I. (1993). Introduction - discourse analysis: The turn in the text. In E. Burman & I. Parker (Eds.), *Discourse analytic research: Repertoires and readings of texts in action* (pp. 1 - 13). London: Routledge.

Burton, T. (1971). *Submission on Nurses' Bill made by the New Zealand Nurses' Association*. Wellington: Archives New Zealand [ABGX W3706, Box 1, Social Services Committee - Nurses Bill folder, 1971].

Caelli, K. (2001). Engaging with phenomenology. *Qualitative Health Research, 11*(2), 273 - 281.

Cain, M. (1999). Advancing nursing practice. *Kai Tiaki Nursing New Zealand, 5*(3), 27.

Cameron, A. (2006, Aug 9). Minister's comments on nurses 'simplistic'. *New Zealand Doctor*.

Canadian Nurses Association. (2005). *The regulation and supply of nurse practitioners in Canada*. Retrieved March 12, 2007, from http://www.cna-nurses.ca/CNA/documents/pdf/publications/Regulation_and_Supply_of_Nurse_Practitioners_in_Canada_e.pdf

Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 267 - 310). London: Sage.

Carey, S. (1977). Submission on Nurses' Bill made by the New Zealand Nurses' Association. *Social Services Committee, No. 2*.

Carey, S. (1984). Professionalism and unionism: Transcending the conflict in New Zealand Nurses Association. In M. G. Smith & Y. T. Shadbolt (Eds.), *Objects and outcomes: The New Zealand Nurses Association 1909 - 1983* (pp. 22 - 44). Wellington: New Zealand Nurses Association.

Carpenter, H. (1971). *An improved system of nursing education for New Zealand: Report of Dr. Helen Carpenter World Health Organization short-term consultant.* Wellington: Department of Health.

Carroll, L. (1872). *Alice in Wonderland, and Through the looking glass, and What Alice found there*. London: Dean & Son.

Carryer, J. (2002). The nurse practitioner role: A process of evolution [Viewpoint]. *Kai Tiaki Nursing New Zealand, 8*(10), 23.

Carryer, J. (2004). Editorial. *Te Puawai The Blossoming, July*, pp. 2 - 3. Retrieved May 9, 2005, from http://www.nurse.org.nz/te_puawai/tp_2704_editorial.htm.

Carryer, J. (2005a, Sept 7). Fronting up to the future [Viewpoint]:Anachronistic employment model stifles change. *New Zealand Doctor*.

Carryer, J. (2005b, July 13). Nurse practitioners no threat to GPs [Viewpoint]. *New Zealand Doctor*.

Carryer, J. (2006, July 22). Press release. *College of Nurses Aotearoa*.

Carryer, J., & Boyd, M. (2003). The myth of medical liability for nursing practice. *Nursing Praxis in New Zealand, 19*(3), 4 -12.

Carryer, J., Dignam, D., Hughes, F., Horsborough, M., & Martin, J. (1999). *Locating nursing in primary health care*. [Committee Report]. Wellington: National Health Committee.

Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2006). The core role of the nurse practitioner: Practice, professionalism and clinical leadership. *Journal of Clinical Nursing, 15*, 1 - 8.

Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2007). The capability of nurse practitioners may be diminished by controlling protocols. *Australian Health Review, 31*(1), 108 - 115.

Cassie, F. (2005a). New hurdles for nurse prescribing. *Nursing Review, 6*(4), 1 - 2.

Cassie, F. (2005b). Nurse prescribing barriers removed. *Nursing Review, 6*(6), 1, 4.

Cassie, F. (2007). New obstacle for nurse prescribing. *Nursing Review, 7*(11), 1.

Castel, R. (1991). From dangerousness to risk. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in governmentality with two lectures and an interview with Michel Foucault* (pp. 281 - 298). Chicago: University of Chicago Press.

Chan, A. (2001, Feb 14). General practitioners face crucial crossroad [Viewpoint]. *New Zealand Doctor*.

Chatterjee, S., Conway, P., Dalziel, P., Eichbaum, C., Harris, P., Philpott, B., et al. (1999). *The new politics : A third way for New Zealand*. Palmerston North, N.Z.: Dunmore Press.

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research.* Thousand Oaks: Sage.

Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research, 14*(8), 1140 - 1150.

Chiarella, M. (1998). Independent, autonomous, or equal: What do we really want? *Clinical Excellence for Nurse Practitioners, 2*(5), 293 - 299.

Chiarella, M. (2002). *The legal and professional status of nursing*. New York: Churchill Livingstone.

Christensen, C. M., Bohmer, R., & Kenagy, J. (2000). Will disruptive innovations cure health care? *Harvard Business Review, 78*(5), 102 - 112.

Chua, W. F., & Clegg, S. (1990). Professional closure: The case of British nursing. *Theory & Society, 19*(12), 135 - 172.

Cimons, M. (1993, June 28). Health reform may expand role of advanced nurses. *Los Angeles Times,* p. 1.

Clark, H. (2002). Higher quality of life for all. *Presidents & Prime Ministers, 11*(1), 12 - 15, 21.

Clark, M. (2005). *History of consultation on prescribing: Unpublished report*. Wellington: NZ Nursing Council.

Clark, M. (2006). *Workforce statistics: 2006 update*. Retrieved March 9, 2007, from http://www.nursingcouncil.org.nz/Workforce%20Stats.pdf

College of Nurse Aotearoa. (2006, November). *Physician assistants: A review of the literature*. Retrieved December 11, 2006, from http://www.nurse.org.nz/temporaryFiles/Physician%20Asst%20Review.pdf

College of Nurses Aotearoa. (2005, August). *Submission of the College of Nurses Aotearoa to the Health Workforce Advisory Committee on the 'Fit for Purpose and for Practice': Review of the medical health workforce in New Zealand*. Retrieved September 22, 2005, from http://www.nurse.org.nz/submissions/subm_fit_for_pp.htm

Concern over new nurse job. (2001, May 6). *Waikato Times,* p. 2.

Connor, M. (2004). *Courage and complexity in chronic illness: Reflective practice in nursing*. Wellington: Daphne Brasnell Associates Press and Whitireia Publishing.

Cooper-Liversedge, B. (1998). Editorial: Ministerial taskforce on nursing. *Nursing Praxis in New Zealand, 13*(3), 2 - 3.

Coppell, V. (2006, Jan 25). The same but then different [Viewpoint]. *New Zealand Doctor.*

Coroners Act. (1988). New Zealand Government: Wellington.

Cottingham, C. (2004). Nursing council no longer democratic [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 10*(10), 4 - 5.

Council formed to help hospitals provide best possible healthcare. (1990). *New Zealand Health & Hospital, 42*(5), 1 - 2.

Cowie, V. (1987). The socio-economic welfare of nurses: Potential for conflict. In *Challenges, options and choices. Papers from the international nursing*

conference hosted by the New Zealand Nurses' Association, held at Rotorua on 5 - 7 August, 1987. Wellington: NZ Nurses' Association.

Crampton, P. (1999). *Third sector primary health care: A report prepared for the National Health Committee*. Wellington: National Health Committee. Retrieved February 17, 2005, from http://www.nhc.govt.nz/publications/phc/phcthird.html.

Crampton, P., Davis, P., & Lay-Yee, R. (2005). Primary care teams: New Zealand's experience with community-governed non-profit primary care. *Health Policy, 72*(2), 233 - 243.

Crampton, P., Dowell, A., & Bowers, S. (2000). Third sector primary health care in New Zealand. *New Zealand Medical Journal, March*, 92 - 96.

Crampton, P., Salmond, C., Blakely, T., & Howden-Chapman, P. (2000). Socioeconomic inequalities in health: How big is the problem and what can be done? *Pacific Health Dialog, 7*(1), 94 - 98.

Crampton, P., Woodward, A., & Dowell, A. (2001). The role of the third sector in providing primary care services: Theoretical and policy issues. *Social Policy Journal of New Zealand, December*(17), 1 - 21.

Crowe, M. (1998). Ministerial Taskforce Report lacks credibility [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 4*(8), 3.

Cumming, J., Raymont, A., Gribben, B., Horsburgh, M., Kent, B., McDonald, J., et al. (2005). *Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy: First report*. Wellington: Health Services Research Centre, Victoria University of Wellington. Retrieved May 30, 2005, from http://www.vuw.ac.nz/hsrc/reports/downloads/FINAL%20-%20Release%20on%2027%20May%202005.pdf.

Daly, W., & Carnwell, R. (2003). Nursing roles and levels of practice: A framework for differentiating between elementary, specialist and advancing nursing practice. *Journal of Clinical Nursing, 12*, 158 - 167.

D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M.-D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19*(Supplement 1), 116 - 131.

Danaher, G., Schirato, T., & Webb, J. (2000). *Understanding Foucault*. St. Leonards, Australia: Allen & Unwin.

Davies, B., & Harré, R. (1991). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour, 20*(1), 43 - 63.

Davis, J. (2005, July 23). *Prescribing upsets NZMA*. Retrieved July 25, 2005, from http://www.stuff.co.nz/stuff/0,2106,3354647a7144,00.html

Deeks, J., Parker, J., & Ryan, R. (1994). *Labour and employment relations in New Zealand* (2nd ed.). Auckland: Longman Paul.

Department of Education. (1972). *Nursing education in New Zealand: Report of a committee set up to consider and report to the Minister of Education on recommendation 1.6 of the report of Dr Helen Carpenter entitled "An improved system of nursing education for New Zealand"*. Wellington: Author.

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

Department of Health. (1977). Report of the Department of Health on the Nurses Amendment Bill. *Social Services Committee, No.1*, SS/75/103.

Department of Health. (1986). *The review of the preparation and initial employment of nurses: Themes, issues, opinions*. Wellington: Government Printer.

Department of Health. (1989). Report of the Department of Health for the year ended 31 March 1989. *Appendix to the Journals of the House of Representatives, VI*(E:10).

Derrida, J. (1976). *Of grammatology* (G. C. Spivak, Trans.). Baltimore: John Hopkins University Press.

Dougherty, I. (1999). *Bricklayers and mortarboards: A history of New Zealand polytechnics and institutes of technology*. Palmerston North, N.Z: Dunmore Press in association with the Historical Branch, Dept. of Internal Affairs.

Dow, D. A. (1995). *Safeguarding the public health: A history of the New Zealand Department of Health*. Wellington, N.Z.: Victoria University Press, in association with the Ministry of Health and with the assistance of the Historical Branch, Department of Internal Affairs.

Dreyfus, H. L., & Rabinow, P. (1983). *Michael Foucault: Beyond structuralism and hermeneutics* (2nd ed.). Chicago: University of Chicago Press.

Dunsford, D. (1996). Too hard a life for a girl: Becoming a nurse at Auckland hospital, 1913 - 1947. *Women Studies Journal, 12*(1), 26 - 42.

Easton, B. (1994). Economic and other ideas behind the New Zealand reforms. *Oxford Review of Economic Policy, 10*(3), 78 - 95.

Education Act. (1989). New Zealand Government: Wellington.

Education Amendment Act. (1990). New Zealand Government: Wellington.

Edwards, G. (2005). Why the push for nurse prescribing? [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 11*(10), 3.

Employment Contracts Act. (1991). New Zealand Government: Wellington.

Employment Relations Act. (2000). New Zealand Government: Wellington.

Fairclough, N. (1993). *Discourse and social change*. Cambridge: Polity.

Fairclough, N. (2001). The discourse of New Labour: Critical discourse analsis. In M. Wetherell, S. Taylor & S. J. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 229 - 266). London: Sage.

Fairman, J. (2003). Commentary: Philosophical and historical bases of advanced practice nursing roles. In E. Sullivan-Marx (Ed.), *Nurse practitioners: Evolution of advanced practice* (4th ed., pp. 54 - 64). New York: Springer.

Fall, M., Walters, S., Read, S., Deverill, M., Lutman, M., Milner, P., et al. (1997). An evaluation of a nurse-led ear care service in primary care: Benefits and costs. *British Journal of General Practice, 47*(424), 699 - 703.

Fealy, G. (2004). 'The good nurse': Visions and values in images of the nurse. *Journal of Advanced Nursing, 46*(6), 649 - 656.

Fehder, W. (2003). Nurse anesthetists: Evolution from critical care practitioners to anesthesia providers. In M. Mezey, D. McGivern & E. Sullivan-Marx (Eds.), *Nurse practitioners: Evolution of advanced practice* (4th ed., pp. 269 - 283). New York: Springer.

Fieldhouse, A. E. (1973). At Victoria University. *New Zealand Nursing Journal, 66*(2), 16 - 17.

First nurse practitioner appointed. (2002). *Kai Tiaki Nursing New Zealand, 8*(1), 7.

Fisher, S. (1995). *Nursing wounds: Nurse practitioners, doctors, women patients, and the negotiation of meaning*. New Jersey: Rutgers University Press.

Ford, L. (1997). Advanced practice nursing: A deviant comes of age ... the NP in acute care. *Heart and Lung: The Journal of Acute and Critical Care., 26*(2), 87 - 91.

Foucault, M. (1974). Truth and judicial forms [Excerpt] (R. Hurley, Trans.). In J. D. Faubion (Ed.), *Power: Essential works of Foucault, 1954-1984: Volume three.* New York: The New Press. Retrieved September 3, 2006, from http://www.foucault.info/documents/foucault.truthAndJudicialForms.en.html.

Foucault, M. (1977a). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). London: Penguin.

Foucault, M. (1977b). Nietzsche, Genealogy, History. (D. F. Bouchard & S. Simon, Trans.). In D. F. Bouchard (Ed.), *Language, counter-memory,*

practice: Selected essays and interviews (pp. 139-164). Ithaca Cornell: University Press.

Foucault, M. (1977c). What is an author? (D. F. Bouchard & S. Simon, Trans.). In D. F. Bouchard (Ed.), *Language, counter-memory, practice: Selected essays and interviews* (pp. 113 - 138). Ithaca Cornell: University Press.

Foucault, M. (1980a). Truth and power (K. Soper, Trans.). In C. Gordon (Ed.), *Power/ knowledge: Selected interviews and other writings, 1972-1977* (pp. 109 - 133). New York: Harvester Wheatsheaf.

Foucault, M. (1980b). Two lectures (K. Soper, Trans.). In C. Gordon (Ed.), *Power/ knowledge: Selected interviews and other writings, 1972-1977* (pp. 78 - 108). New York: Harvester Wheatsheaf.

Foucault, M. (1981). The order of discourse: Inaugural lecture at the College de France, given December 2, 1970. In R. Young (Ed.), *Untying the text: A post-structuralist reader* (pp. 48 - 78). Boston: Routledge & Kegan Paul.

Foucault, M. (1983a). On the genealogy of ethics. In H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault, beyond structuralism and hermeneutics* (2nd ed., pp. 229 - 254). Chicago: The University of Chicago Press.

Foucault, M. (1983b). The subject and power [Afterword]. In H. L. Dreyfus & P. Rabinow (Eds.), *Michael Foucault: Beyond structuralism and hermeneutics* (2nd ed., pp. 208 - 226). Chicago: University of Chicago Press.

Foucault, M. (1988). Technologies of the self. In L. H. Martin, H. Gutman & P. H. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16 - 49). Amherst: University of Massachusetts Press.

Foucault, M. (1989). *The archaeology of knowledge* (A. M. S. Smith, Trans.). London: Routledge.

Foucault, M. (1990). *The history of sexuality: An introduction. Volume One* (R. Hurley, Trans.). New York: Vintage Books.

Foucault, M. (1991a). *The Foucault reader*. London: Penguin Books.

Foucault, M. (1991b). Governmentality: Lecture given at the College de France, February 1978. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in governmentality, with two lectures by and an interview with Michel Foucault* (pp. 87 - 104). Chicago: University of Chicago Press.

Foucault, M. (1991c). Politics and the study of discourse. In P. Miller (Ed.), *The Foucault effect: Studies in governmentality with two lectures and an interview with Michel Foucault* (pp. 53 - 72). Chicago: University of Chicago Press.

Foucault, M. (1991d). Questions of method. In P. Miller (Ed.), *The Foucault effect: Studies in governmentality, with two lectures by and an interview with Michel Foucault* (pp. 73 - 87). Chicago: University of Chicago Press.

Foucault, M. (1993). About the beginning of the hermeneutics of the self: Two lectures at Dartmouth. *Political Theory, 21*(2), 198 - 227.

Foucault, M. (1994). *The birth of the clinic: An archaeology of medical perception* (A.M. Sheridan Smith, Trans.). New York: Vintage Books.

Foucault, M. (1997a). The birth of biopolitics (R. Hurley, Trans.). In P. Rabinow (Ed.), *Ethics: Essential works of Foucault 1954 - 1984 Volume One* (pp. 73 - 79). London: Penguin.

Foucault, M. (1997b). Society must be defended (R. Hurley, Trans.). In P. Rabinow (Ed.), *Ethics: Essential works of Foucault 1954 - 1984 Volume One* (pp. 59 - 85). London: Penguin.

Foucault, M. (1997c). Technologies of the self (R. Hurley, Trans.). In P. Rabinow (Ed.), *Ethics: Essential works of Foucault 1954 - 1984 Volume One* (pp. 223 - 251). London: Penguin.

Foucault, M. (2002). *Madness and civilisation: A history of insanity in the age of reason* (R. Howard, Trans.). London: Routledge.

Foucault, M. (2004). The hermeneutics of the subject: Lectures at the College de France, 1981 - 1982 (G. Burchell, Trans.). In F. Gros (Ed.). New York: Picador.

Fougere, G. (2001). Transforming health sectors: New logics of organizing in the New Zealand health system. *Social Science & Medicine, 52*, 1233 - 1242.

Fountain, B. (1999, March 3). Simple art of diagnosis [Editorial]. *New Zealand Doctor.*

Fountain, B. (2001, Sept 12). Another kick in the guts [Editorial]. *New Zealand Doctor.*

Fox, J. (2005, Sept 13). *New prescribing role will add power to primary care team [Media statement]*. Retrieved October 10, 2005, from http://www.rnzcgp.org.nz/news/statements/2005/prescribing_role.htm

Fox, N. J. (1997). Is there life after Foucault? In A. Petersen & R. Bunton (Eds.), *Foucault: Health and medicine* (pp. 31 - 50). London: Routledge.

Freeman, M., deMarrais, K., Preissle, J., Roulston, K., & St Pierre, E. A. (2007). Standards of evidence in qualitative research: An incitement to discourse. *Educational Researcher, 36*(1), 25 - 33.

Freidson, E. (1970). *Professional dominance: The social structure of medical care*. New York: Atherton Press.

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

Gallagher, P. (1997). Editorial. *Nursing Praxis in New Zealand, 12*(2), 2 - 3.

Gallagher, P. (1998). Proving the competence of nurses. *Kai Tiaki Nursing New Zealand, 4*(5), 16 - 17.

Gamarnikow, E. (1978). Sexual division of labour: The case of nursing. In A. Kuhn & A. Wolpe (Eds.), *Feminism and materialism: Women and modes of production* (pp. 96 - 123). London: Routledge and Paul.

Gardner, G., Carryer, J., Dunn, S., & Gardner, A. (2004). *Nurse practitioner standards project: Report to the Australian Nursing and Midwifery Council*. Dickson ACT: Austalian Nursing and Midwifery Council.

Gardner, G., Gardner, A., & Proctor, M. (2004). Nurse practitioner education: A research-based curriculum structure. *Journal of Advanced Nursing, 47*(2), 143-152.

Gardner, H., & McCoppin, B. (1986). Vocation, career or both? Politicization of Australian nurses, Victoria 1984 - 1986. *The Australian Journal of Advanced Nursing, 4*(1), 25 - 35.

Gastaldo, D. (1997). Is health education good for you? Re-thinking health education through the concept of biopower. In A. Petersen & R. Bunton (Eds.), *Foucault: Health and medicine* (pp. 113-133). London: Routledge.

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms*. Wellington: Institute of Policy Studies and Health Services Research Centre, Victoria University.

Gergen, M. M., & Gergen, K. J. (2000). Qualitative inquiry: Tensions and transformations. In Y. S. Lincoln (Ed.), *Handbook of qualitative research* (2nd ed., pp. 1025 - 1046). Thousand Oaks, California: Sage Publications.

Giddens, A. (1999). Better than warmed-over porridge. *New Statesman, 128*(4423), 25 - 26.

Giddens, A. (2004a). Did they foul up my Third Way? *New Statesman, 133*(4691), 24 - 25.

Giddens, A. (2004b). We can and should take action if the earnings of the rich set them apart from society. *New Statesman, 133*(4707), 50 - 53.

Goldfinch, S. (1998). Remaking New Zealand's economic policy: Institutional elites as radical innovators 1984-1993. *Governance, 11*(2), 177 - 207.

'Good night nurse' to anaesthesia plan. (2004). *Nursing Review, 5*(5), 3.

Gordon, C. (1991). Governmental rationality: An introduction. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in*

governmentality, with two lectures by and an interview with Michel Foucault (pp. 1-51). Chicago: University of Chicago Press.

Gorman, D., & Scott, J. (2005). Is a concentration on generalist medical practitioners the solution to the New Zealand health workforce crisis? *New Zealand Family Physician, 32*(6), 368 - 371.

Gorman, D., & Scott, J. (2006). Time for a medical educational change in time [Editorial]. *Internal Medicine Journal, 36*(11), 687 - 689.

Gracez, T. (1998). Taskforce questionnaire fails to reach nurses [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 4*(5), 5.

Graham, R. (Writer) (2005, November 27). Nurses' pay [Radio broadcast]. In P. Tolley (Producer). Wellington: Radio New Zealand.

Guba, E. G., & Lincoln, Y. S. (2000). Controversies, contradictions, confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 191 - 215). Thousand Oaks, California: Sage Publications.

Guilliland, K. (1998, Oct 9). Self-interested doctors quick to criticise midwives. *The National Business Review*.

Gunn, D. (1999). Linking nurse prescribing and advanced practice. *Kai Tiaki Nursing New Zealand, 5*(5), 25.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 19*(Supplement 1), 188-196.

Hall, S. (2001a). Foucault: Power, knowledge and discourse. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse theory and practice: A reader* (pp. 72 - 92). London: Sage.

Hall, S. (2001b). The spectacle of the Other. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse theory and practice: A reader* (pp. 324 - 344). London: Sage.

Hall, S. (Ed.). (1997). *Representation: Cultural representations and signifying practices*. London: Sage.

Hallam, J. (1998). From angels to handmaidens: Changing constructions of nursing's public image in post-war Britain. *Nursing Inquiry, 5*(1), 32 - 42.

Hanks, P. (Ed.). (1981). *Collins dictionary of the English language*. Sydney: Collins.

Harding, T. (2003). Male nurses: The struggle for acceptance. *Kai Tiaki Nursing New Zealand, May*, 17 - 20.

Harding, T. (2005). *Constructing the 'other': On being a man and a nurse.* Unpublished PhD thesis, University of Auckland, Auckland.

Harris, D., Smith, M., & Betts, J. (2003). Nurse practitioners must retain clinical focus. *Kai Tiaki Nursing New Zealand, 9*(18), 26 - 27.

Hart, J. (1980). The history of the practice nurse subsidy scheme. *Kai Tiaki Nursing New Zealand, 73*(12), 3, 27.

Hartmann, H., Kester, D., Davies, F., & Geneve, R. (1997). *Plant propagation: Principles and practices* (7th ed.). New Jersey: Prentice Hall.

Hathaway, D. (2006). *Introducing the Doctor of Nursing Practice*. Retrieved March 12, 2007, from http://www.medscape.com/viewarticle/528346

Hatherley, N. (1989). Professionalism and the socio-economic welfare of nurses. In *Priorities for practice: Papers presented at the Norman Peryer forum, 25 - 27 November, 1988*. Wellington: Nursing Education and Research Foundation.

Hattersley, R. (1999). Up and down the social ladder: Meritocracy doesn't work. *New Statesman, 128*(4421), 25 - 27.

Hawkins, L. (1989). *Nurses who see themselves as independent practitioners*. Wellington: NZNA.

Health Act. (1956). New Zealand Government: Wellington.

Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations. (1996). New Zealand Government: Wellington.

Health and Disability Commissioner Act. (1994). New Zealand Government: Wellington.

Health Occupational Registration Acts Amendment: Amendments to Nurses Act 1977. (1998). New Zealand Government: Wellington.

Health Practitioners Competence Assurance Act. (2003). New Zealand Government: Wellington.

Health professionals push limits of standing order regulations. (2007). *Nursing Review, 7*(10), 3.

Health Reforms Research Team. (2003, November). *Interim report on health reforms 2001: Research project*. Retrieved December 2, 2003, from http://www.sog.vuw.ac.nz/vuw/fca/sog/files/Interim%20Report%20on%20Health%20Reforms%202001.pdf

Health Workforce Advisory Committee. (2005). *Fit for purpose and for practice: A review of the medical workforce in New Zealand, Consultation document*. Wellington: Author.

Hefford, M., Crampton, P., & Foley, J. (2005). Reducing health disparities through primary care reform: The New Zealand experiment. *Health Policy, 72*(1), 9 - 23.

Henriques, J., Hollway, W., Urwin, C., Venn, L., & Walkerdine, V. (1984). The point of departure. In J. Henriques, W. Hollway, C. Urwin, L. Venn & V. Walkerdine (Eds.), *Changing the subject : Psychology, social regulation and subjectivity* (pp. 1 - 9). London: Methuen.

Heywood, A. (1992). *Political ideologies: An introduction*. Hampshire: Palgrave Macmillan.

Hill, S. (2001, Oct 24). Tariana Turia enrages diehard ProCare boss [Conference report]. *New Zealand Doctor*.

Hines, G. H. (1974). Motivational influences in job satisfaction. *New Zealand Nursing Journal, 67*(6), 18 - 20.

Hodgson, P. (2006, July 21). *Primary health – Low fees are good but what's next? Address to the Dunedin School of Medicine*. Retrieved July 23, 2006, from http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=26545

Hodgson, P. (2006, November 29). *Inaugural national conference for nurse practitioners [Dunedin]*. Retrieved February 27, 2007, from http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=27909

Hoffart, S. (2002). Up where she belongs. *Next, June,* 36 - 39.

Holdaway, M. (1993). Where are the Maori nurses who were to become those 'efficient preachers of the gospel of health?' *Nursing Praxis in New Zealand, 8*(1), 25 - 34.

Holidays Act. (2003). New Zealand Government: Wellington.

Holloway, K. (1998). *Preparation for advanced practice - making a difference: A literature review*. Wellington: Nurse Educators in the Tertiary Sector (NETS).

Hook, D. (2001). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *Theory and Psychology, 11*(4), 521 - 547.

Hook, D. (2005). Genealogy, discourse, 'effective history': Foucault and the work of critique. *Qualitative Research in Psychology, 2*, 3 - 31.

hooks, b. (1990). *Yearning: Race, gender, and cultural politics*. Boston: South End Press.

Hospital & Related Services Taskforce. (1988). *Unshackling the hospitals: Report of the hospital and related services taskforce*. Wellington: Author.

Hospitals Bill. (1909, December 3). *The Evening Post,* p. 3.

Hughes, F. (2002). Reflections from 'down under about NPs 'up top' [Editorial]. *Journal of Psychosocial Nursing & Mental Health Services, 40*(7), 6-8.

Hughes, F. (2003, June). *Nursing sector update* (Report). Wellington: Ministry of Health.

Hughes, F., & Carryer, J. (2002). *Nurse practitioners in New Zealand* (Report). Wellington: Ministry of Health. Retrieved November 1, 2005, from http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/16f47058bbbc49d3cc256bf900721fa6/$FILE/NursePractitionersinNZ.pdf.

Hughes, L. (1990). Professionalising domesticity: A synthesis of selected nursing historiography. *Advances in Nursing Science, 12*(4), 25 - 31.

Huntington, N., & Bale, T. (2002). New Labour: New Christian democracy? *Political Quarterly, 73*(1), 44 - 50.

Hutnyk, J. (2005). Hybridity. *Ethnic and Racial Studies, 28*(1), 79 - 102.

Incorporated Societies Act. (1908). New Zealand Government: Wellington.

International Council of Nurses. (n.d.). *Credentialing fact sheet*. Retrieved May 30, 2005, from http://www.icn.ch/matters_credentialing.htm

Jacobs, S. (1998). Advanced nursing practice in New Zealand: 1998. *Nursing Praxis in New Zealand, 13*(3), 4 - 12.

Jacobs, S. (1999). Advanced nursing practice: Refining a New Zealand approach. *Vision, 1*(8), 24 - 26.

Jacobs, S. (2000). Credentialling: Setting standards for advanced nursing practice. *Nursing Praxis in New Zealand, 16*(2), 38 - 46.

Jacobs, S. (2005). *Advanced nursing practice and the nurse practitioner: New Zealand nursing's professional project in the late 20th century.* Unpublished PhD thesis, Massey University, Palmerston North.

Janesick, V. (2000). The choreography of qualitative research design. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 379 - 400). Thousand Oaks, California: Sage Publications.

Jesson, B. (1999). *Only their purpose is mad*. Palmerston North: Dunmore Press.

Johnston, M. (2005). Call for technicians to perform surgery. *New Zealand Herald,* p. A3.

Jones, M. (2002). Interprofessional practice - the meaning for nurses. In E. Papps (Ed.), *Nursing in New Zealand: Critical issues, different perspectives* (pp. 138 - 149). Auckland: Pearson.

Jones, M. (2004). Nurse prescribing: A case study in policy influence. *Journal of Nursing Management, 12*(4), 266 - 272.

Jones, M. E., & Clark, D. (1997). Increasing access to health care: A study of pediatric nurse practitioner outcomes in a school-based clinic. *Journal of Nursing Care Quality, 11*(4), 53 - 60.

Kaplan, E. A. (1990). Sex, work and motherhood: The impossible triangle. *Journal of Sex Research, 27*(3), 409 - 425.

Kelly, M. (Ed.). (1994). *Critique and power: Recasting the Foucault/Habermas debate*. London: MIT Press.

Kelsey, J. (1998). *The New Zealand experiment*. Auckland: Auckland University Press.

Kent, B., Horsburgh, M., Lay-Yee, R., Davis, P., & Pearson, J. (2005). *Nurses and their work in primary health care: The national primary medical care survey (NatMedCa), 2001/02. Report 9*. Wellington: Ministry of Health.

King, B., Fletcher, M. P., & Callon, L. G. (1982). *Post-basic nursing education in New Zealand: Report of a survey undertaken in selected geographical areas, Special report series 62*. Wellington: Management Services and Research Unit, Department of Health.

Kinnersley, P., Anderson, E., Parry, K., Clement, J., Archard, L., Turton, P., et al. (2000). Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care. *British Medical Journal, 320*(7241), 1043 - 1048.

Kinross, N. J. (1975). Contemporary New Zealand Issues. *New Zealand Nursing Journal, January*, pp. 22- 23.

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

Kinross, N. J. (1984b). Politics and power. In M. G. Smith & Y. T. Shadbolt (Eds.), *Objects and outcomes: The New Zealand Nurses Association 1909 - 1983* (pp. 94 - 117). Wellington: New Zealand Nurses Association.

Knutson, D. (1998). *Welfare reform in New Zealand: Moving toward a work-based welfare system (an Ian Axford Fellowship report)*. Retrieved April 5, 2006, from http://www.fulbright.org.nz/voices/axford/docs/knutsond.pdf

Kumar, R. (2004, September 8). Getting your slice of capitation pie. *New Zealand Doctor*.

Labour Relations Act. (1987). New Zealand Government: Wellington.

Lacombe, D. (1996). Reforming Foucault: A critique of the social control thesis. *British Journal of Sociology, 47*(2), 332 - 352.

Lambie, M. I. (1956). *Historical development of nursing in New Zealand 1890 - 1950*. Wellington: Department of Health.

Lange, D. (1996). David Lange : MP 1977-96, PM 1984-89 [Sound recording]. Wellington: Replay Radio, Radio New Zealand.

Larson, M. S. (1977). *The rise of professionalism: A sociological analysis*. Berkeley: University of California Press.

Lather, P. (1993). Fertile obsession:Validity after poststructuralism. *Sociological Quarterly, 34*(4), 673 - 693.

Lemke, T. (2000). *Foucault, governmentality, and critique [Conference presentation]*. Retrieved November 21, 2003, from http://www.thomaslemkeweb.de/engl.%20texte/Foucault,%20Governmentality,%20and%20Critique%20IV.pdf

Lemke, T. (2001). 'The birth of bio-politics': Michel Foucault's lecture at the College de France on neo-liberal governmentality. *Economy & Society, 30*(2), 190-207.

Levitas, R. (2004). Let's hear it for Humpty: Social exclusion, the third way and cultural capital. *Cultural Trends, 13*(2), 41 - 56.

Lewis, N. (2004). Geographies of 'The New Zealand Experiment'. *GeoJournal, 59*(2), 161 - 166.

Lincoln, Y. S., & Denzin, N. K. (2000). The seventh moment: Out of the past. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 1047 - 1065). Thousand Oaks, California: Sage Publications.

Lines, K. (2001). A philosophical analysis of evidence-based practice in mental health nursing. *Australian & New Zealand Journal of Mental Health Nursing, 10*(3), 167-175.

Listener. (2001). Turf war: Who will see you now - the doctor or the nurse? *New Zealand Listener, November 24*, p. 38.

Litchfield, M. (2002). Nurse practitioner role limits the profession [Viewpoint]. *Kai Tiaki Nursing New Zealand, 8*(8), 20.

Lorde, A. (1984). The master's tools will never dismantle the master's house. In *Sister outsider: Essays and speeches* (pp. 110 - 113). New York: The Crossing Press.

Luxon, N. (2004). Truthfulness, risk, and trust in the late lectures of Michel Foucault. *Inquiry, 47*(5), 464 - 489.

Lyotard, J.-F. (1984). *The postmodern condition: A report on knowledge* (G. Bennington & B. Massumi, Trans.). Manchester: Manchester University Press.

MacGregor, D. (1901). Hospitals and charitable institutions of the Colony: Report by the inspector of hospitals. *Appendix to the Journals of the House of Representatives, Vol. IV*(H:22).

MacGregor, D. (1906). Hospitals and charitable institutions of the Colony: Report by the inspector of hospitals. *Appendix to the Journals of the House of Representatives, Vol. IV*(H:22).

Mackay, B. (2003). General practitioners' perceptions of the nurse practitioner role: An exploratory study. *New Zealand Medical Journal, 116*(1170), 8 pages.

Maclean, H. (1909). The New Zealand Trained Nurses' Association [Editorial]. *Kai Tiaki Nursing New Zealand, 2*(3), 77.

Maclean, H. (1932). *Nursing in New Zealand.* Wellington: Tolan Printing Company.

Maling, T. (2000). Extended prescribing rights - a statutory right or hard earned priviledge? *New Zealand Medical Journal, 113*(1119), 410 - 411.

Malloy, T. (2006). On the same side [Viewpoint]. *The Networker, June*, p. 6. Retrieved September 3, 2006, from http://www.rgpn.org.nz/newsletters/june2006.pdf.

Maloney-Moni, J. (2004). *Kia mana: A synergy of wellbeing*. Nelson: Copy Press.

Manchester, A. (1998). Nurses gain right to prescribe. *Kai Tiaki Nursing New Zealand, 4*(5), 12.

Mann, D. (1996). What is postmodernism? *Philosophy Today, September*(23).

Mansfield, N. (2000). *Subjectivity: Theories of the self from Freud to Haraway*. New York: New York University Press.

Martin, R. (1988). Truth, power, self: An interview with Michel Foucault. In L. H. Martin, Gutman, H., & Hutton, P. H. (Ed.), *Technologies of the self: A seminar with Michel Foucault.* Amherst: University of Massachusetts Press.

Mason, D. J., Cohen, S. S., O'Donnell, J. P., Baxter, K., & Chase, A. B. (1997). Managed care organizations' arrangements with nurse practitioners. *Nursing Economics, 15*(6), 306 - 314.

Mason, L. (Writer) (2005, July 29). Nurses push for prescription power [TV news item]. Wellington: TV ONE. Retrieved August 3, 2005, from http://tvnz.co.nz/view/video_popup_windows_skin/600844.

Maw, H. (2005). *The challenge of developing primary health care nurse practitioner roles in rural New Zealand.* Unpublished Master's thesis, Otago Polytechnic, Dunedin.

McCloskey, B. A., & Diers, D. K. (2005). Effects of New Zealand's health reengineering on nursing and patient outcomes. *Medical Care, 43*(11), 1140 - 1146.

McDonald, K. (2005, Sept). AMA cops a blast over role reversal. *Australian Nursing Review,* p. 1.

McDougall, M. (1997). Discovering our past through exploring a register from Wellington hospital, 1916 - 1925. In N. Chick & J. Rodgers (Eds.), *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery* (pp. 23 - 32). Palmerston North: Massey University Department of Nursing & Midwifery.

McGregor, S. (2001). Neoliberalism and healthcare. *International Journal of Consumer Studies, 25*(2), 82 - 89.

McHoul, A., & Grace, W. (1993). *A Foucault primer: Discourse, power and the subject*. Victoria: Melbourne University Press.

McKegg, A. (1992). The Maori health nursing scheme: An experiment in autonomous health care. *New Zealand Journal of History, 26*(2), 145 - 160.

McKillop, A. (1995). Herstory: Akenei Hei - pioneer and nurse leader. *Nursing Praxis in New Zealand, 10*(3), 33 - 34.

McLennan, G. (2004). Travelling with vehicular ideas: The case of the Third Way. *Economy and Society, 33*(4), 484 - 499.

McLintock, A. H., (Ed.). (1966). Social security. In *Te Ara: An Encyclopaedia of New Zealand*: Retrieved April 5, 2006, from http://www.teara.govt.nz/1966/S/SocialSecurity/ScopeOfLegislationOf1938/en.

Medical Practitioners Act. (1995). New Zealand Government: Wellington.

Medicines (Designated Prescriber: Nurse Practitioners) Regulations. (2005). New Zealand Government: Wellington.

Medicines (Designated Prescriber: Nurses Practising in Aged Care and Child Family Health) Regulations. (2001). New Zealand Government: Wellington.

Medicines (Standing orders) Regulations. (2002). New Zealand Government: Wellington.

Medicines Act. (1981). New Zealand Government: Wellington.

Medicines Amendment Act. (1999). New Zealand Government: Wellington.

Medicines Regulations. (1984). New Zealand Government: Wellington.

Messervy, L. (1992). The rise of the independent nurse practitioner. In Nursing Education and Research Foundation (Ed.), *The nation's health: The need and our response. National nurses' forum, 15 - 17 May 1987, Waitkato University* (pp. 211 - 233). Wellington: Author.

Meylan, G. (2004, June 2). Little research on GP substitution. *Doctor*.

Mill, J. S. (1975). *Three essays: On liberty, Repressive government, The subjection of women*. London: Oxford University Press. First published 1859.

Ministerial Taskforce on Nursing. (1998). *Report of the ministerial taskforce on nursing: Releasing the potential of nursing*. Wellington: Ministry of Health.

Ministry of Health. (1996). *Reform of health sector occupational regulation statutes: Draft reports for discussion purposes*. Wellington: Author.

Ministry of Health. (2001a). *New Zealand Health Strategy*. Wellington: Author, Retrieved March 9, 2007, from http://www.moh.govt.nz/moh.nsf/0/FB62475D5D911E88CC256D42007BD67E/$File/newzealandhealthstrategy.pdf.

Ministry of Health. (2001b). *Primary health care strategy*. Wellington: Author. Retrieved February 10, 2005, from http://www.moh.govt.nz/moh.nsf/0/7BAFAD2531E04D92CC2569E600013D04/$File/PHCStrat.pdf.

Ministry of Health. (2001, May 15). *Joint statement from Nursing Council of New Zealand and Ministry of Health: New nurse practitioners will be a boost for health system*. Retrieved July 23, 2003, from http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/e82d7db8d40df68ccc256a4d000d93df?OpenDocument

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

Ministry of Health. (2004). *Regulatory impact: Amending the regulatory framework for designated prescribers*. Wellington: Author. Retrieved June 4, 2005, from http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/32e84b31f3d5d61cc256e920015ccdb?OpenDocument.

Ministry of Health. (2005). *Restricted activities under the Health Practitioners Competence Assurance Act 2003*. Retrieved September 22, 2006, from http://www.moh.govt.nz/moh.nsf/0/7F1BA28F1E7997D6CC2571650015AD66

Ministry of Health. (2005, July). *Implementing nurse practitioner prescribing [Consultation document]*. Wellington: Author.

Ministry of Health. (2006). *Nurse practitioner employment and development working party*. Retrieved November 18, 2006, from http://www.moh.govt.nz/moh.nsf/indexmh/nursepractitioner-working-party

Minogue, M., & Goodyear-Smith, F. (2005). The black hole of general practice manpower. *New Zealand Family Physician, 32*(5), 317 - 322.

Minto, R. (2004, July 14). Facing the nursing funding dilemma [Viewpoint]. *New Zealand Doctor*.

Minto, R. (2006). The future of practice nursing. *New Zealand Family Physician, 33*(3), 169 - 172.

Misuse of Drugs Amendment Regulations. (2005). New Zealand Government: Wellington.

Moller, P., & Begg, E. (2005). Independent nurse prescribing in New Zealand [Editorial]. *New Zealand Medical Journal, 118*(1225), 4 pages.

Morrissey, B. (2003, Nov 19). Bridging ethos gap between IPA and PHO [Viewpoint]. *New Zealand Doctor*.

Mundinger, M. (2002). Through a different looking glass. *Health Affairs, 21*(1), 163-165.

Mundinger, M., Kane, R. L., Lenz, E. R., Totten, A. M., Tsai, W.-Y., Cleary, P. D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association, 283*, 59 - 68.

Murchie, E. R., & Spoonley, P. (1995). *Report to the Nursing Council of New Zealand on cultural safety and nursing education in New Zealand, July - September 1995*. Wellington: Cultural Safety Review Committee.

Murdoch, J. C., & Gurr, E. (1987). Funding of primary medical care: Ensuring quality at what cost. *NZ Medical Journal, 100*, 352 - 355.

Murphy, R. (1984). The structure of closure: A critique and development of the theories of Weber, Collins, and Parkin. *The British Journal of Sociology, 35*(4), 547 - 567.

Naughton, M. (2005). 'Evidence-based policy' and the government of the criminal justice system - only if the evidence fits! *Critical Social Policy, 25*(1), 47 - 69.

Neville, S. (2002). The nurse practitioner advisory committee of New Zealand. *Te Puawai The Blossoming, July*, pp. 16 - 17.

Neville, S. (2004). Consumer alliances. *New Zealand Nursing Review, 5*(8), 8.

New Prescribers Advisory Committee. (2005). *Recommendations to the Minister of Health: Extending limited independent prescribing authority to nurse practitioners*. Retrieved August 23, 2006, from http://www.newhealth.govt.nz/npac/recommendations/recommendation-nursepractitioners.pdf

New Prescribers Advisory Committee. (2005, June 21). *Minutes: Nursing Council application*. Retrieved September 25, 2006, from http://www.newhealth.govt.nz/npac/minutes/210605.htm

New Zealand Institute of Economic Research. (2004). *Ageing New Zealand and health and disability services: Demand projections and workforce implications, 2001 - 2021. A discussion document*. Wellington: Ministry of Health. Retrieved November 18, 2006, from http://www.nzier.org.nz/SITE_Default/SITE_Publications/x-files/12087.pdf.

New Zealand Medical Association. (1999). *Submission to the Health Select Committee on the Medicines Amendment Bill*. Wellington: Parliament.

New Zealand Parliamentary Debates. (1901). Hospital Nurses Registration Bill. *CXVII*(30 July to 28 August).

New Zealand Parliamentary Debates. (1971, December 3). Nurses Bill. *377*(Nov 23 - Dec 17), 5068 - 5069.

New Zealand Parliamentary Debates. (1971, November 26). Nurses Bill. *377*(Nov 23 - Dec 17), 4953 - 4978.

New Zealand Parliamentary Debates. (1990, August 21). Nurses amendment bill: Second reading.

New Zealand Parliamentary Debates. (1998, June 17). Health Occupational Registration Acts Amendment Bill: Consideration of Report of Health Committee.

New Zealand Parliamentary Debates. (1998, March 4). Nursing: Questions to Ministers.

New Zealand Public Health and Disability Act. (2000). New Zealand Government: Wellington.

New Zealand Qualifications Authority. (2003/2007). *Approval and accredition of courses leading to degrees and related qualifications*. Wellington: Author. Retrieved March 25, 2007, from http://www.nzqa.govt.nz/for-providers/aaa/docs/degrees-app-acc.pdf.

North, N. (1991). Primary care services: In search of alternative ways of providing services that are affordable, accessible and appropriate - a review of recent literature. *Nursing Praxis in New Zealand, 6*(3), 11 - 18.

NP hurdle too high? (2006). *Nursing Review, 6*(9), 3.

NPAC-NZ, Carryer, J., & Hughes, F. (2005, April). *Nurse practitioners: The next step - creating sustainable development and employment opportunities*. Wellington: NPAC-NZ.

Nuccio, S. A., Lingen, D., Burke, L. J., Kramer, A., Ladewig, N., Raaum , J., et al. (1996). The clinical practice developmental model: The transition process. *Journal of Nursing Administration, 26*(12), 39 - 37.

Nurse Educators in the Tertiary Sector. (1997). *Position statement: Post registration nursing education*. Dunedin: Author.

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

Nurse Practitioner Advisory Committee-New Zealand. (2005). *Business case tool kit to establish the position of nurse practitioner*. Retrieved September 5, 2006, from http://www.nurse.org.nz/nurse_practitioner/Business%20case%202.pdf

Nurses Act. (1971). New Zealand Government: Wellington.

Nurses Act. (1977). New Zealand Government: Wellington.

Nurses Amendment Act. (1990). New Zealand Government: Wellington.

Nurses Amendment Act. (1999). New Zealand Government: Wellington.

Nurses and Midwives Registration Act. (1925). New Zealand Government: Wellington.

Nurses may replace GPs as point of first contact. (2006, July 22). *Dominion Post,* p. 2.

Nurses Registration Act. (1901). New Zealand Government: Wellington.

Nurses Regulations. (1973). Wellington: Government Printer.

Nurses Regulations. (1979). Wellington: Government Printer.

Nursing taskforce granted a month's extension. (1998). *Kai Tiaki Nursing New Zealand, 4*(4), 5.

The nursing year in review. (2005). *Nursing Review, 5*(9), 5 - 7.

NZ Medical Council. (1999). *Submission to the Health Select Committee on the Medicines Amendment Bill*. Wellington: Parliament.

NZ Medical Council. (2005). *Continuing professional development and recertification*. Retrieved January 5, 2006, from http://www.mcnz.org.nz/portals/1/MED_Recertification_Oct05.pdf

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

NZ Nurses' Association. (1981). National executive minutes. *Kai Tiaki Nursing New Zealand, December*, 22 - 23.

NZ Nurses' Association. (1984). *Nursing education in New Zealand: A review and statement of policy*. Wellington: Author.

NZ Nurses' Association. (1987). *A proposal for a clinical career path for nurses*. Wellington: Author.

NZ Nurses' Association. (1991a). Being professional. *Kai Tiaki Nursing New Zealand, April*, 18 - 19.

NZ Nurses' Association. (1991b). *A proposal for career development for nurses in clinical practice*. Wellington: Author.

NZ Nurses Organisation. (1993, June). *Myths and reality: The effects of the Employment Contracts Act on nurses in New Zealand (1991 - 1993).* Paper presented at the ICN Congress, Madrid, Spain. Retrieved December 18, 2004, from http://www.nzno.org.nz/SITE_Default/SITE_About_Us/x-files/2243.pdf.

NZ Nurses Organisation. (1998, July 30). *Ministerial taskforce on nursing: Why is NZNO no longer part of the Ministerial taskforce on nursing? [Flyer]*. Wellington: Author.

NZ Nurses Organisation. (1998, September). *Building partnerships*. Wellington: Author.

NZ Nurses Organisation. (2000, June). *Advanced nursing practice: NZNO position statement*. Wellington: Author.

NZ Nurses Organisation. (2003). *NZNO College and Section accreditation process*. Retrieved July 26, 2004, from http://www.nzno.org.nz/SITE_Default/SITE_Professional/Advanced_Nursing_Practice/collegesection_accreditation.asp

NZ Nurses Organisation. (2003, August). *Nurse practitioners in New Zealand: NZNO position statement*. Wellington: Author.

NZ Nurses Organisation. (2006, June). *Fair pay at last for public hospital nursing staff*. Retrieved September 1, 2006, from http://www.nzno.org.nz/Site/News/Latest/FairPayAtLast.aspx

NZ Nurses Organisation and NZ Medical Association. (2006, December). *Primary health care multi-employer collective agreement*. Retrieved April 26, 2007, from http://www.nzno.org.nz/Site/Campaigns/Parity.aspx

NZ Nursing Council. (1977). *Approval of Schools of Nursing*. Wellington: Author.

NZ Nursing Council. (1994/1997). *Strategic plan*. Wellington: Author.

NZ Nursing Council. (1996). *Guidelines for cultural safety in nursing and midwifery education*. Wellington: Author.

NZ Nursing Council. (1996/97). *Standards for registration of comprehensive nurses*. Wellington: Author.

NZ Nursing Council. (1997). Report of the Nursing Council of New Zealand for the year ended 31 March 1997. *Appendix to the Journals of the House of Representatives*(E:18).

NZ Nursing Council. (1998a). *Framework, guidelines, and competencies for post-registration education*. Wellington: Author.

NZ Nursing Council. (1998b). Report of the Nursing Council of New Zealand for the year ended 31 March 1998. *Appendix to the Journals of the House of Representatives*(E:18).

NZ Nursing Council. (1999). *Framework for post-registration nursing education*. Wellington: Author.

NZ Nursing Council. (2000). *New Zealand registered nurses, midwives and enrolled nurses: Survey of educational qualifications*. Wellington: Author. Retrieved March 27, 2006, from http://www.nursingcouncil.org.nz/educqual.pdf.

NZ Nursing Council. (2001). *Towards a competency assurance framework for nursing*. Wellington: Author.

NZ Nursing Council. (2002, November 7). Medicines Amendment Act 1999, Medicines (Designated prescriber: Nurses practising in aged care and child family health) regulations 2001. *New Zealand Gazette, no.163*(Notice 6045), 4105 - 4107.

NZ Nursing Council. (2004a). *Health Practitioners Competence Assurance Act 2003: News update*. Wellington: Author.

NZ Nursing Council. (2004b). *Nurse practitioner competencies*. Retrieved November 22, 2005, from http://www.nursingcouncil.org.nz/competenciesnp.pdf

NZ Nursing Council. (2004, September 15). Notice of scopes of practice and related qualifications prescribed by the Nursing Council of New Zealand. *New Zealand Gazette*(Notice 6268), 2958.

NZ Nursing Council. (2005). *Medicines (Designated prescriber: Nurse practitioners) regulations*. Retrieved October 21, 2005, from http://rangi.knowledge-basket.co.nz/regs/regs/text/2005/2005266.txt

NZ Nursing Council. (2005, April). *Implementing nurse practitioner prescribing [Consultation document]*. Wellington: Author.

NZ Nursing Council. (2005, November 10). Medicines (Designated prescriber: Nurse practitioners) notice. *New Zealand Gazette, no.188*(Notice 7428), p. 4750.

NZ Nursing Council. (2006, July). *News update from the chief executive*. Wellington: Author.

O'Connor, T. (1995). Developing competencies: NZNO has decided to 'participate actively' in the development of competencies for nursing and midwifery. *Kai Tiaki Nursing New Zealand, 1*(2), 23.

O'Connor, T. (1996). What's the future for nursing education? *Kai Tiaki Nursing New Zealand, 2*(7), 28 - 29.

O'Connor, T. (1998). Musings on 1998 ... *Kai Tiaki Nursing New Zealand, 4*(11), 2.

O'Connor, T. (2003a). Relishing the challenges of rural nursing... Marg Eckhoff. *Kai Tiaki Nursing New Zealand, 9*(2), 16 - 17.

O'Connor, T. (2003b). Why the angst about nurse practitioners? *Kai Tiaki Nursing New Zealand, 9*(6), 13 - 14.

O'Connor, T. (2005). Nurse prescribing a reality at last: It's been a long time coming but nurse prescribing has finally arrived. *Kai Tiaki Nursing New Zealand, 11*(9), 10 - 11.

O'Connor, T., & Manchester, A. (2005). Frustrating battle for nurse prescribing. *Kai Tiaki Nursing New Zealand, 11*(8), 12.

Ogle, K. R., & Glass, N. (2006). Mobile subjectivities: Positioning the nonunitary self in critical feminist and postmodern research. *Advances in Nursing Science, 29*(2), 171 - 182.

Oliver, H. (1998). Why NZNO refused to endorse Taskforce Report. *Kai Tiaki Nursing New Zealand, 4*(7), 12 - 13.

Oliver, H. (1999). Nursing Council's proposals under fire. *Kai Tiaki Nursing New Zealand, 5*(4), 17.

Olssen, M. (2000). Ethical liberalism, education and the 'New Right'. *Journal of Education Policy, 15*(5), 481-508.

Olssen, M. (2003). Structuralism, post-structuralism, neo-liberalism: Assessing Foucault's legacy. *Journal of Education Policy, 18*(2), 189 - 202.

Opie, A. (1999). Knowledge-based teamwork. In K. Dew & P. Davis (Eds.), *Health and society in Aotearoa New Zealand* (pp. 182 - 198). Melbourne: Oxford University Press.

Pantano, T. (2003). Loss of NP title causes demoralisation. *Kai Tiaki Nursing New Zealand, 9*(11), 20.

Papps, E. (1997). *Knowledge, power and nursing education in New Zealand: A critical analysis of the construction of the nursing identity.* Unpublished PhD thesis, University of Otago, Dunedin, NZ.

Papps, E. (2001). (Re)positioning nursing: Watch this space. *Nursing Praxis in New Zealand, 17*(2), 4-12.

Papps, E., & Kilpatrick, J. (2002). Nursing education in New Zealand - past, present and future. In E. Papps (Ed.), *Nursing in New Zealand: Critical issues, different perspectives* (pp. 1 - 13). Auckland: Pearson.

Parker, I., & Burman, E. (1993). Against discursive imperialism, empiricism and constructionism: Thirty-two problems with discourse analysis. In E. Burma & I. Parker (Eds.), *Discourse analytic research: Repertoires and readings of text in action* (pp. 155 - 172). London: Routledge.

Paterson, B. (1987). The potential contribution of the clinical nurse specialist in acute care in the New Zealand setting. *Nursing Praxis in New Zealand, 3*(1), 3 - 9.

Paterson, B. (1989). *Making a difference: The lived world of nursing practice in an acute care setting.* Unpublished Masters Thesis, Massey, Palmerston North.

Patton, P. (1979). Of power and prisons. In P. Patton & M. Morris (Eds.), *Michel Foucault: Power, truth, strategy* (pp. 109 - 147). Sydney: Feral Publications.

Pearson, L. (2004). Sixteenth annual legislative update: How each state stands on legislative issues affecting advanced nursing practice. *Nurse Practitioner, 29*(1), 26 - 51.

Peckham, S. (1999). Primary care purchasing: Are integrated primary are provider/purchasers the way forward? *PharmacoEconomics, 15*(3), 209 - 215.

Pegasus Medical Group. (1999). *Submission to the Health Select Committee on the Medicines Amendment Bill.* Wellington: Parliament.

Pepperell, G. (2003). Former nurse practitioner disillusioned with nursing [Letter to the editor]. *Kai Tiaki Nursing New Zealand, 9*(4), 3.

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.

Petersen, A. (1997). Risk, governance and the new public health. In R. Bunton (Ed.), *Foucault: Health and medicine* (pp. 189 - 206). London: Routledge.

Phillips, S. J. (2006). 18th Annual legislative update. *Nurse Practitioner, 31*(1), 6 - 38.

Pitts, A. (1984). Nursing Services. In M. G. Smith & Y. T. Shadbolt (Eds.), *Objects and outcomes: The New Zealand Nurses Association 1909 - 1983* (pp. 45 - 63). Wellington: New Zealand Nurses Association.

Porter, S. (1992). The poverty of professionalization: A critical analysis of strategies for the occupational advancement of nursing. *Journal of Advanced Nursing, 17*(6), 720 - 726.

Potter, J. (1996). Discourse analysis and constructionist approaches: Theoretical background. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences*. Leicester: BPS Books. Retrieved September 29, 2005, from http://www.lboro.ac.uk/departments/ss/depstaff/staff/bio/JPpages/Richardson%20Handbook%20Chapter%20for%20web.htm.

Powell, I. (2005, Feb 3). *Boards should consider employing salaried GP's*. Retrieved 14 February, 2005, from http://www.scoop.co.nz/mason/stories/GE0502/S00014.htm

Powers, P. (2003). Empowerment as treatment and the role of health professionals. *Advances in Nursing Science, 26*(3), 227 - 238.

Practice nurse scheme extended. (1974). *Kai Tiaki Nursing New Zealand, 67*(1), 19 - 20.

Price, S. (1995). Patricia Benner: Exploring her writings and their relevance for the New Zealand nursing world. *Nursing Praxis in New Zealand, 10*(1), 4 - 11.

Primary Health Care Nursing Expert Advisory Group. (2003). *Investing in health: Whakatohutia te oranga tangata. A framework for activating primary health are in New Zealand* (Report). Wellington: Ministry of Health.

Rabinow, P. (Ed.). (1997). *Ethics: Essential works of Foucault 1954 - 1984 Volume One*. London: Penguin.

Rabinow, P., & Rose, N. (Eds.). (2003). *The essential Foucault: Selections from essential works of Foucault, 1954 - 1984*. New York: The New Press.

Rasch, R. F. R., & Frauman, A. C. (1996). Advanced practice in nursing: Conceptual issues. *Journal of Professional Nursing, 12*(3), 141-146.

Reid, A. (1965a). The place of nursing in the university. *New Zealand Nursing Journal, 58*(9), 5 - 9.

Reid, A. (1965b). *Report on nursing education in New Zealand*. Christchurch.

Renouf, P. (2002). Nurse practitioners improving outcomes [Editorial]. *Kai Tiaki Nursing New Zealand, 8*(10), 2.

Renouf, P. (2005). Nurse practitioner (NP) prescribing in New Zealand: A NP's response to the editorial by Drs Moller and Begg. *New Zealand Medical Journal, 118*(1226), 4 pages.

Richardson, L. (2000). Writing a method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 923 - 948). Thousand Oaks, California: Sage Publications.

Ridley, M. (1993). *The Red Queen: Sex and the evolution of human nature*. London: Viking.

Riggins, S. H. (1997). The rhetoric of othering. In S. H. Riggins (Ed.), *The language and politics of exclusion: Others in discourse* (pp. 1 - 30). London: Sage.

Rillstone, G. (2005, Sept 21). Independent nurse moniker dropped. *New Zealand Doctor.*

Rishworth, P. (1992). Civil liberties. In H. Gold (Ed.), *New Zealand politics in perspective* (3rd ed., pp. 143 - 159). Auckland, N.Z.: Longman Paul.

Rodgers, J. A. (1985). *Nursing education in New Zealand, 1883 to 1930: The persistence of the Nightingale ethos.* Unpublished Masters thesis, Massey University, Palmerston North.

Rolfe, G. (2006). Judgements without rules: Towards a postmodern ironist concept of research validity. *Nursing Inquiry, 13*(1), 7-15.

Rose, N., & Miller, P. (1992). Political power beyond the state: Problematics of government. *The British Journal of Sociology, 43*(2), 173 - 205.

Ross, M. (2001, April 20). Doctors' competition issue on examination couch. *National Business Review,* p. 17.

Royal New Zealand College of General Practitioners. (2005). *The value of general practice 2005*. Retrieved October 10, 2005, from http://www.rnzcgp.org.nz/about/docs/value_gp_2005.pdf

Royal New Zealand College of General Practitioners. (2005, December). *Membership survey general practice in New Zealand part I: General practitioner demographics, working arrangements and hours worked.* Wellington: Author.

Royal New Zealand College of General Practitioners. (2006, July). *Forecasting GP workforce capacity: Towards an understanding of GP workforce capacity, long-term forecasting and benchmarking tools, Occasional paper 8*. Wellington: Author.

Royal New Zealand College of General Practitioners. (2006, June). *Membership survey general practice in New Zealand part III: Urban and rural New Zealand*. Wellington: Author.

Royal New Zealand College of General Practitioners. (2006, March). *Membership survey general practice in New Zealand part II: Future workforce intentions, teamwork and remuneration*. Wellington: Author.

Royal New Zealand College of General Practitioners. (1999). *Submission to the Health Select Committee on the Medicines Amendment Bill*. Wellington: Parliament.

Safriet, B. J. (2002). Closing the gap between can and may in health-care providers' scopes of practice: A primer for policymakers. *Yale Journal on Regulation, 19*(2), 301 - 334.

Said, E. (1983). *The world, the text, and the critic*. Cambridge: Harvard University Press.

Sakamoto, R. (1996). Japan, hybridity and the creation of colonialist discourse. *Theory, Culture and Society, 13*(3), 113 - 128.

Salmon, B. E. (1968). Have you read the WHO Expert committee on nursing, fifth report? *New Zealand Nursing Journal, 61*(1), 11, 13.

Salmon, B. E. (1971). Insulation bred those myths of nursing. *New Zealand Nursing Journal, April*, pp. 5 - 7.

Salmon, B. E. (1982). A view on training of nurses in hospitals (original published 1969). In P. Carroll, A. Fieldhouse & S. Shaw (Eds.), *A profession in transition: Issues in nursing in New Zealand over two decades 1961 - 1981*. Wellington: C.L. Bailey Nursing Education Trust.

Samson, C. (1999). Biomedicine and the body. In C. Samson (Ed.), *Health studies* (pp. 3 - 21). Oxford: Blackwell.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1 - 8.

Sargison, P. A. (2001). *"Essentially women's work": A history of general nursing in New Zealand.* Unpublished Master's thesis, University of Otago, Dunedin.

Sarup, M. (1993). *An introductory guide to post-structuralism and postmodernism* (2nd ed.). New York: Harvester Wheatsheaf.

Sarup, M. (1996). *Identity, culture and the postmodern world*. Edinburgh: Edinburgh University Press.

School's new title to avoid confusion. (1970). *The New Zealand Nursing Journal, July*, p. 20.

Shadbolt, Y. (1983). Nursing education: A major shift. *New Zealand Nursing Journal, January*, pp. 6 - 9.

Shamian, J. (1997). How nursing contributes towards quality and cost-effective health care. *International Nursing Review, 44*(3), 79 - 84, 90.

Shaw, J. P. (1994). *Prescribing rights in New Zealand: A public discussion paper*. Wellington: Ministry of Health.

Shaw, S. (1986). Nursing and primary health care... part 2. *Kai Tiaki Nursing New Zealand, 79*(6), 12 -14.

Sheddan, A. (2001, May 23). New players in practice. *New Zealand Doctor*.

Shiell, A., Kenny, P., & Farnworth, M. G. (1993). The role of the clinical nurse co-ordinator in the provision of cost-effective orthopaedic services for elderly people. *Journal of Advanced Nursing, 18*(9), 1424 - 1428.

Shum, C., Humphreys, A., Wheeler, D., Cochrane, M.-A., Skoda, S., & Clement, S. (2000). Nurse management of patients with minor illnesses in general practice: multicentre, randomised controlled trial. *British Medical Journal, 320*(7241), 1038 - 1042.

Simon, J. (1997, November 26). Nurse prescribing badly timed and ill conceived [Viewpoint]. *New Zealand Doctor*.

Smith, A. (1776). *An inquiry into the nature and causes of the wealth of nations*. Retrieved January 14, 2005, from, from http://www.mondopolitico.com/library/wealthofnations/b4c1.htm

Smith, B. (1972). Be realistic [Letter to the editor]. *New Zealand Nursing Journal, 65*(10), 6 - 7.

Smith, B. (1998). *The final chapter: A history of the last 21 years of the Auckland branch of the New Zealand Nurses' Association 1968 - 1989*. Auckland: New Zealand Nurses Organisation.

Smith, M. G., & Shadbolt, Y. T. (1984). NZNA: Structure and function 1909 - 1983. In M. G. Smith & S. Yvonne T (Eds.), *Objects and outcomes: The New Zealand Nurses Association 1909 - 1983* (pp. 1 - 21). Wellington: New Zealand Nurses Association.

Smith, T. (1999). Advanced nursing practice: A three-day decision making workshop. *Nursing Praxis in New Zealand, 14*(1), 58.

Social Security Act. (1938). New Zealand Government: Wellington.

Spence, D., & Anderson, M. (2006). *Implementing a prescribing practicum within a Masters programme in advanced nursing practice: A pilot study*. Auckland/Napier: Auckland University of Technology & Eastern Institute of Technology.

St John, P. (2001, Sept 12). Nurse practitioners say no to oversight. *New Zealand Doctor*.

State Sector Act. (1988). New Zealand Government: Wellington.

Statistics New Zealand. (2005, June). *New Zealand income survey*. Retrieved September 1, 2006, from http://www2.stats.govt.nz/domino/external/pasfull/pasfull.nsf/7cf46ae26dc

b6800cc256a62000a2248/4c2567ef00247c6acc25709100182686?OpenDocument

Stephens, B. (1987). Social policy reform: In retrospect and prospect. In A. Bollard & R. Buckle (Eds.), *Economic liberalisation in New Zealand* (pp. 299 - 229). Wellington: Allen & Unwin.

Stevenson, A. F. (1997). *Realities and rhetoric: General hospital nursing in New Zealand 1945 to 1960.* Unpublished Masters Thesis, Victoria University of Wellington, Wellington.

Stevenson, C. (2004). Theoretical and methodological approaches in discourse analysis. *Nurse Researcher, 12*(2), 17 - 29.

Stodart, K. (1990). After the act. *Kai Tiaki Nursing New Zealand, 83*(9), 21 - 22.

Stodart, K. (1991). Professional need seen in Aotearoa. *Kai Tiaki Nursing New Zealand, July*, 13.

Storey, D. (1983). Nursing - A profession not a trade. *New Zealand Nursing Journal, October*, pp. 3 - 4.

Sutch, W. B. (1966). *The quest for security in New Zealand: 1840 - 1966.* Wellington: Oxford University Press.

Taylor, S. (2001). Locating and conducting discourse analytic research. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 5 - 48). London: Sage.

Therapeutic Products and Medicines Bill. (2006). Retrieved May 10, 2007, from http://www.parliament.nz/NR/rdonlyres/7575C1BC-B34D-460E-9791-D174C1C9245A/49296/DBHOH_BILL_7738_4029.pdf

Thompson, J. (1972). The new alliance. *Kai Tiaki Nursing New Zealand, 65*(8), 5 - 7.

Thornton, G. (2004). Surviving the PHO minefield. *Health Advisor, 19*(Spring), 1 - 2. Retrieved February 23, 2006, from http://www.grantthornton.co.nz/Assets/documents/pubSeminars/HA_%2020spring%202004.pdf.

Tilah, M. (1996). The medical model to the management model: Power issues for nursing. *Nursing Praxis in New Zealand, 11*(2), 16 - 22.

Tilyard, M., Gurr, E., Dovey, S., & Krebs, V. (2006). General practitioners' actual and scheduled charges for consultations with children and the elderly in South Island PHOs. *New Zealand Family Physician, 33*(3), 184 - 187. Retrieved September 181, 2006, from http://www.rnzcgp.org.nz/news/nzfp/June2006/Tilyard_June_2006.pdf.

Treasury. (1984). *Economic management: Briefing to the incoming government*. Wellington: Author. Retrieved April 19, 2006, from http://www.treasury.govt.nz/briefings/1984/big84-2-ch1-6.pdf.

Treasury. (1987). *Government management: Briefing to the incoming government*. Wellington: Author. Retrieved March 29, 2006, from http://www.treasury.govt.nz/briefings/1987/.

Trim, S. (1998). Preparing for the professional future. *Kai Tiaki Nursing New Zealand, 4*(10), 26.

Trim, S. (2001). Clinical career pathways: An overview. *Kai Tiaki Nursing New Zealand, 7*(2), 22 - 23.

Trim, S. (2002). Developing the role of nurse practitioner. *Kai Tiaki Nursing New Zealand, 8*(4), 27.

Trim, S. (2004a). Research on nurse practitioner role underway. *Kai Tiaki Nursing New Zealand, 10*(2), 28.

Trim, S. (2004b). *Shaping the nurse practitioner model in New Zealand: Critical partnerships.* Paper presented at the ICN Nurse Practitioner Conference, Netherlands.

Turia, T. (2001). *'On the Pulse': An address to the 4th annual general practice CME conference in Wairakei, October 12*. Retrieved January 30, 2006, from http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=12154

Uncovering the stories of the first registered nurses. (2001). *Kai Tiaki Nursing New Zealand, 7*(9), 6.

Upton, S. (1991). *Your health and the public health: A statement of government health policy [The green and white paper]*. Wellington: GP Print.

van der Stoep, L. (2006, October 8). Doctors' aides touted as answer to workload woes. *Sunday Star Times,* p. 5.

Venning, P., Durie, A., Roland, M., Roberts, C., & Leese, B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal, 320*, 1048 - 1053.

Waikato Management School. (2006). *Financial statistics : 2005 New Zealand business benchmarking survey*. Hamilton, N.Z: Management Research Centre, University of Waikato.

Ware, A., & Goodin, R. E. (1990). Introduction. In A. Ware & R. E. Goodin (Eds.), *Needs and welfare* (pp. 1 - 11). London; Newbury Park: Sage Publications.

Watts, J., Loveridge, E., Goble, S., Collins, M., Tindall, L., & Morton, J. (1986). Implications of internal assessment on nursing education. *New Zealand Nursing Journal, 79*(7), 20 - 23.

Weatherall, A. (2002). *Gender, language and discourse*. Sussex: Routledge.

Weedon, C. (1987). *Feminist practice and poststructuralist theory*. New York: Blackwell.

Wetherell, M., Taylor, S., & Yates, S. (2001a). *Discourse as data: A guide for analysis*. London: Sage.

Wetherell, M., Taylor, S., & Yates, S. (2001b). *Discourse theory and practice: A reader*. London: Sage.

"White Stocking". (1974). Beware blues [Letter to the editor]. *New Zealand Nursing Journal, November*, p. 10.

Wilkinson, J. A. (2001a). *A mantle of protection? A critical analysis of the personal safety of district nurses.* Unpublished Masters thesis, Massey University, Wellington.

Wilkinson, J. A. (2001b). Nurses must be aware of their power. *Kai Tiaki Nursing New Zealand, 7*(1), 20.

Wilkinson, J. A. (2002). Creating a culture of workplace safety. *Kai Tiaki Nursing New Zealand, 8*(6), 14 - 15.

Williams, G. (1992). Nurse prescribing authority. In Nursing Education and Research Foundation (Ed.), *The nation's health: The need and our response. National nurses' forum, 15 - 17 May 1987, Waitkato University* (pp. 298 - 303). Wellington: Author.

Willis, E. (1989). *Medical dominance: The division of labour in Australian health*. Sydney: Allen & Unwin.

Wilson, B. (1998). NZNO and the Taskforce [Editorial]. *Kai Tiaki Nursing New Zealand, 4*(7), 2.

Wilson, D. (2001). *Transforming nursing education: A legitimacy of difference.* Unpublished PhD thesis, Canterbury University, Christchurch.

Wilson, K. F. (1995). *Professional closure: The case of the professional development of nursing in Rotorua 1840-1934.* Unpublished Masters thesis, Massey University, Palmerston North.

Wilson, K. F. (1998). Professional closure: Constructing the image of New Zealand nursing 1880 - 1940. *Nursing Praxis in New Zealand, 13*(1), 12 - 22.

Winch, S., Creedy, D., & Chaboyer, W. (2002). Governing nursing conduct: The rise of evidence-based practice. *Nursing Inquiry, 9*(3), 156 - 161.

Winslade, J. M. (2005). Utilising discursive positioning in counselling. *British Journal of Guidance & Counselling, 33*(3), 351 - 364.

Winterson, J. (1996). *Oranges are not the only fruit*. London: Vintage.

Witz, A. (1990). Patriarchy and professions: The gendered politics of professional closure. *Sociology, 24*(4), 675 - 690.

Wood, P. (1992). Efficient preachers of the gospel of health: The 1898 scheme for educating Maori nurses. *Nursing Praxis in New Zealand, 7*(1), 12 - 21.

Wood, P., & Papps, E. (2001). *Safety to practise: Reflections of chairpersons of the Nursing Council of New Zealand 1971 - 2001*. Wellington: The Nursing Council of New Zealand.

Work in progress: Towards the development of guidelines for advanced nursing practice in New Zealand. (1999). *Proceedings from the conference/workshop hosted by the College of Nurses Aotearoa, March 1 - 3, 1999.*

Work starts on prescribing. (1998). *Kai Tiaki Nursing New Zealand, 4*(8), 9.

World Health Organisation. (1966). *WHO expert committee on nursing: 5th report* (No. 347). Geneva: Author. Retrieved April 7, 2006, from http://whqlibdoc.who.int/trs/WHO_TRS_347.pdf.

World Health Organization. (1978). *The declaration of Alma-Ata.* Retrieved July 23, 2004, from http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

World Health Organization. (1986). *The Ottawa charter for health promotion*. Retrieved July 23, 2004, from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

Wright, P., Mukherji, A., & Kroll, M. (2001). A re-examination of agency theory assumptions: Extensions and extrapolations. *Journal of Socio-Economics, 30*(5), 413 - 430.

Wynyard, R. (2006, April 19). Uncertainty over use of NPs. *New Zealand Doctor*.

Yardley, L. (1997). Introducing material. In L. Yardley (Ed.), *Material discourses of health and illness* (pp. 1 - 24). London: Routledge.

Young, R. J. C. (1995). *Colonial desire: Hybridity in theory, culture and race*. London: Routledge.