"They Can't See What we See"

Voices and Standpoint of Twelve Plunket Nurses

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ABSTRACT

This thesis is drawn from the responses of twelve Plunket nurses to questions in a semi-structured long interview with the aim of establishing their standpoints. On analysis the twelve separate standpoints came together as one voice. Although interview questions were wide-ranging, diverse topics were brought together by an emphasis on relationship and change. Change was seen to be occurring at all levels, from the practice of Plunket nurses and the Plunket organisation to the New Zealand Health system and the wider society. Responses to questions on motivation, career, education and the wider social context of Plunket nurses add depth to the study and reveal a consistency and integrity on the part of those who responded.

Quality of relationship proved to be the key to the standpoint of these twelve nurses. The principles underlying their views on their practice are consistent with those outlined by Freire (1972), namely: love, humility, faith in people, mutual trust, hope and critical thinking. Responses reveal twelve nurses sharing a commitment to those who use their services. Such a commitment acts as a safeguard, protecting against a relationship characterised by dependency, and favouring a movement towards increasing capability and self-sufficiency for those using Plunket services. The standpoint that is reflected here, places these twelve Plunket nurses within a discipline of nursing which is based on a broad definition of health and a caring philosophy.

ACKNOWLEDGMENTS

First and foremost, the successful completion of this thesis rests upon the generosity of the twelve busy Plunket nurses who agreed to participate, and who then conscientiously thought and spoke freely about their views.

I am also grateful to my supervisors, Andrew Trlin, Celia Briar and Mary Nash, who have advised and guided and been notable for their patience. They, particularly Andrew, have made a major contribution to the final sharpness and cohesion of this study and report.

Of the people whose ideas have become part of this thesis, some are mentioned in the bibliography, but many are not. Some are no longer remembered. Nevertheless, I acknowledge and am grateful to them all.

I also appreciate the grant from the Massey University Graduate Research Fund covering costs for transport and audio tapes.

Nearest to me, my family and friends have stood by me, and listened when I have needed to talk—at times at great length. And they are still with me.

Thank you.

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INTRODUCTION

When I began this study, I was interested in investigating a voice or standpoint which did not appear to be represented in the academic literature. As its title suggests, the standpoint, or standpoints, of Plunket nurses is the main topic of this thesis, but the possibility of a changing relationship between Plunket nurses and those using Plunket services[1] is of major concern also. In this introduction, I will begin with a discussion of my reasons for choosing this topic. I will then present the themes that were explored in the long interviews and my research approach, and end with an outline of the structure of the thesis.

REASONS FOR CHOICE OF TOPIC

The major reasons for my choice of this topic are embedded in my personal history (see Lambert 1986). In retrospect, I can see the events of my life as a series of movements both towards and away from the mainstream of dominant culture. In the process, I have occupied different positions, each offering a fresh viewing point, and I have learnt that reality is mediated by perspective. This became very apparent in 1968, when the experience of living on an income below the official poverty level, in an inner city area of Minneapolis—known as the 'asphalt reservation'—led me to explore difference; to explore different ways of seeing. I learnt that even in one city there could be many different worlds. I moved within and between these worlds: my family, which included two babies and my New Zealand partner, whose other main world was that of student; the white, working class reality of my downstairs neighbour; our neighbourhood which had all the characteristics of poverty and oppression, but which was also, at that time, one of the birthplaces of the American Indian Movement; the worlds of other 'foreign students' and their families; the realities of the upper middle class Minnesotans who reached out to us; the worlds of the university and the people who worked there; and so on. I witnessed and participated in the clashes of view that occurred as people crossed into realities that were different from their own. And I saw that it was not easy for people to change their 'world view,' but as a consequence of these clashes some people did make major adjustments to the way they saw reality.

I see social policy as arising from the influence of a variety of voices issuing from a rich cultural mosaic. Words like 'culture,' 'reality,' 'world,' 'ideology,' 'ethnicity' all

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[1] To avoid the market metaphor of 'client' and 'consumer' and the passivity of 'patient,' I will use the term 'service user' for those using the Plunket nursing service.

relate to different ways of seeing that evolve out of our different experiences. Sometimes many voices are silenced by the power of a few, or even of one, but at the end of the 1960s in the United States there was a clamour of voices making themselves heard. In the brief history of New Zealand there has also been a time of many being silenced, with a more persistent and insistent call to be heard coming from a wider variety of groups in recent decades. It could be said that since the signing of Te Tiriti o Waitangi in 1840 there have been two main cultures in Aotearoa/New Zealand, with one, that of the more recent immigrants, dominating the other. 'New Zealand' can be seen as a structure placed over and silencing the earlier 'Aotearoa'.[2] But even within the dominant culture there are voices that are silenced. My aim in this thesis was to record one of these voices, namely that of Plunket nurses.

Although I have not worked as a Plunket nurse, the territory is not completely unfamiliar to me. I became a student nurse on 1 April 1959. Since then I have continued to participate in the New Zealand health system as a paid worker, an unpaid worker and as a user of health services. For eighteen months, when my children were very young, we as a family used the services of Plunket. During that time, we saw two Plunket nurses, one of whom was supportive and approachable while the other was didactic, criticising and threatening. From 1979 to 1984, my work as a public health nurse brought me into close contact with Plunket nurses. As part of a commitment to supporting other health initiatives I shared a lunch hour once a week with the Plunket nurse who worked in the same area as myself. In this hour we were able to offer each other support by discussing problems and possible solutions, and I gained further understanding of what it was like to be a Plunket nurse.

Additionally, as I listened to the stories of the wide variety of people with whom I worked, I began to see Aotearoa/New Zealand from a multiplying number of perspectives (eg. that of parents, children, schoolteachers, school principals, workers, bosses, Maori, Pakeha, new immigrants of many different nationalities, other health professionals, volunteer community workers, Department of Health administrators, bureaucrats from many different organisations, etc.). At that time my public health nurse colleagues were using phrases like: 'we see with their eyes,' 'we walk in their shoes.' My Minnesota experience had primed me for this. I could see that within any social system there were a number of standpoints, a number of 'realities,' all of them understandable from their particular starting point. My view of health broadened and I could see that numerous diverse factors affected health.

During the following three years (1984-1987), teaching student nurses in a comprehensive programme gave me the opportunity to reflect on my community

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[2] In most instances, because I will be referring to what Smith (1987) has called the 'relations of ruling,' I will use 'New Zealand' in this thesis.

nursing experience and to consolidate my views on health. I found that I had developed a strong interest in how health services were organised and valued in this country. I had learnt through my practice as a public health nurse and through the emphasis on health rather than sickness within the Department of Health, that somehow health and ill-health had become inverted in our thinking in New Zealand. Within the dominant Pakeha culture the influential view of health (that is, the biomedical model) had a sickness focus, and mind and body were divorced from each other in a bifurcated system of thought and practice. In contrast, the people who were dispossessed by Pakeha had a comprehensive view of **health**.

In reading for this degree, I found that the literature did not reflect a diversity of standpoints, and that there were writers who had reached a similar conclusion (eg: Haraway 1988). Graham (1985) argued that the unpaid work of people caring for others at home represents a major contribution to health which is generally not acknowledged. Bickley (1990), talking about women caring for very young children at home, said:

> This group of health providers are unpaid, unrecognised and often harshly judged. Recognition of the value of their work by 'professional' care providers and policy-makers would radically change the perceived place of mothers in the health service.

In many studies the effectiveness (or otherwise) of the work of nurses was explored, but the attempt to capture social reality from the standpoints of nurses was rarely made. In effect, those who were studied were silenced. This silencing of nurses paralleled the invisibility of those caring for others at home.

As I wished to study a reality that does not feature in the academic literature, that of nurses was very attractive. Furthermore, my own observations of a changing Plunket nurse practice were not reflected in the literature. The results from a number of studies (see Chapter 1) suggested that satisfaction with the Plunket nursing service correlated positively with the socio-economic status of the service users. In some of these studies support was found for Hart's Inverse Care Law, that those in most need receive the least care (Hart 1971), whereas the changes I had observed suggested that Plunket nurses in some areas were working to make their practice more accessible and more acceptable to a wide range of people.

Briefly, I wanted to explore a part of the health system that is not well represented in the literature, and to document a standpoint with a health rather than a sickness focus; a standpoint reflecting up, down and across social hierarchies.

THEMES EXPLORED WITHIN THE LONG INTERVIEW

My aim was to obtain a broad picture, through the use of a semi-structured, long interview technique based on a series of wide ranging themes. These themes included: the composition of the New Zealand health system; the value of the Plunket nursing service; what learning they found to be of use to them in their work; what motivated them to work as Plunket nurses; what they thought of the career structure for nurses within Plunket; what kinds of relationships they had with other health workers and with the people using their services; what they found to be rewarding; what they saw as constraining; what were the personal costs in working as a Plunket nurse; where they found support; and finally, what changes they were observing and experiencing, and what they thought about these changes (see Appendix 2).

THE APPROACH THAT WAS EMPLOYED AND WHY

My approach rests on my view of reality and consequent interpretation of the literature, as well as on my goals for the study. As mentioned, life experience has taught me about very different realities, and I have seen people acting according to their particular standpoint as if there were no alternatives. Blumer (1969) saw meaning as derived from and arising out of social interaction with others. Through our interactions with each other we construct our social world, and we act on these constructions as though they are as real as the physical constructions that house us. Sociologists have asked questions about the variance of views of reality across and within cultures (eg: Berger and Luckman 1967). In Abercrombie's (1980:54) opinion:

> The notion that every definable social location has at least the theoretical possibility of having a particular belief-system that is appropriate to it is the most important tenet of the conventional sociology of knowledge.

Content analysis of different standpoints reveals areas of agreement and disagreement. For instance, there might be agreement that a particular social hierarchy exists, but disagreement over the position of power within it. Moreover, the process of interpretation will be from the idiosyncratic perspective of the interpreter. Haraway (1988) argued that there is no detached position from which a person can record reality objectively. Personal belief and ethics, whether or not they are derived from shared systems of thought, shape the scientific process. My voice, my perspective is one of the organising elements in this thesis, and therefore, I have been explicit about this. Being clear about my own standpoint will, I hope, enable me to avoid projecting it onto the people whom I have interviewed, and will assist others in their evaluation of this thesis.

Any sector within a society is composed of a number of groups, each with its own particular focus and each with something to offer. Each contribution is of value, because only this group with this particular vision can offer it. Even within a group each person will have a particular perspective. To achieve a composite picture of schooling in Canada, Smith (1987 151-177) advocated an exploration of the differing standpoints of parents, teachers, school administrators and bureaucrats. 'The map is not the territory,' but as more standpoints are charted, our recorded view of social reality becomes more composite, more reflective of the diversity of the territory. In reference to social systems, I have used the metaphor of mosaic. The focus of this study is on a small part of that cultural mosaic: namely, the standpoint of Plunket nurses. Given that my intent was to record a particular view of reality—to establish a picture—I have used a qualitative approach (Kirk and Miller 1986:9). Thus, the study is descriptive.

THE STRUCTURE OF THIS THESIS

There are five parts to this study: the focus shifts from the social context of the nurses to the nurses themselves; then it moves from their views on Plunket within the New Zealand health system to their experience of work and social change; and in the final chapter I draw together the key themes from the previous chapters.

Part One, includes two chapters. In the first of these, I draw from the literature to develop a context for what is to follow. This includes discussions on the New Zealand health system, the origins, organisational structure and effectiveness of The Royal New Zealand Plunket Society, a brief review of the development of nursing, and a reflection on the nature of relationship. In Chapter 2, as well as describing the method that I have followed and my rationale for using it, I discuss how I resolved significant ethical issues associated with this research exercise and offer a brief introduction to the nurses themselves. The latter helps to establish who these people are and sets the tone for what is to follow. Because of issues related to identification (hence confidentiality) I am not specific about individual nurses, but in Chapters 3-9 (drawn from the interviews), they effectively introduce themselves.

In the two chapters in Part Two the focus is on the nurses themselves. Responses to questions centred around their motivation to work for Plunket, aspirations in relation to this work, and views on career are presented in Chapter 3. Chapter 4 is derived from questions about education; about knowledge gained both informally through life experience and formally in courses related to nursing practice. The main thrust of these questions was to reveal what learning was of most value to those participating.

Nurses' views on the particular system in which they worked is the topic of Part Three, with the New Zealand health system as the subject in Chapter 5, and Plunket's part within it discussed in Chapter 6. Thus these chapters serve to depict nurses' reflections on the social context which exerts some power over them. Since the value of Plunket was also queried, the responses reported indicate participants' attitudes towards health.

In Part Four, which consists of three chapters, the focus shifts to the work itself. The questions that formed the basis for Chapter 7 focused on relationship and practice-related goals. This chapter emerged as the key to the whole study. A changing relationship with service users was central to what I had thought was happening within Plunket, and it turned out that this relationship was also central to the concerns of those who participated. In summary, Chapter 7 covers community related goals, and goals and relationships with other health workers as well as with people using Plunket nursing services. When I practised as a public health nurse, I was aware that at times I felt hindered from realising my goals, while at other times I felt supported. I found that both support and constraint came from a number of directions, including the organisation which employed me, the wider social arena, and myself. In Chapter 8, I present the nurses responses to questions about rewards, constraints, personal cost and support. The experience of change is the central concern within Chapter 9. Questions on change were wide-ranging, including: the experience of change at the wider societal level and within Plunket itself; the effects of Government policy on the work of Plunket nurses; change perceived as constructive and as detrimental; change that could be implemented that would improve the Plunket nursing service; and nurses' own involvement in the process of change. Some of these questions reflected up and down the social hierarchies in which the nurses are placed, and therefore, helped to establish the nurses' standpoints in relation to others.

At the beginning of each of the chapters drawn from the transcriptions, I indicate why I asked the particular questions on which these chapters are based. Overall my intent, in Chapters 3 to 9, was to establish the main themes in the nurses' responses. In Chapter 10 I draw these themes together, and review the process that I have followed. This discussion and critique forms the fifth and final part of the thesis.