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TOWARDS NURSING ADVOCACY:

A SOCIO-POLITICAL PROCESS.

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University.

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1991.

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ABSTRACT

This thesis provides a reflexive critique of the power structures which constrain nursing actions in the practice setting, an abortion clinic, of the registered nurses who participated in this study. The development of abortion services, like other health services for women, has been based on a medical ideology of health which has created many ethical dilemmas for nurses. One of the most complex of these is the extent to which nurses should fulfill the role of client advocate. While the literature on nursing advocacy has been prolific, published research in this area is scant.

The theoretical assumptions of critical social science, provide the basis for the methodological approach of action research adopted in this study. In depth, unstructured interviews involving exchange of dialogue amongst the participants with the researcher focused on the participants' experiences of their own nursing practice, with a view to uncovering and removing constraints, which had prevented them fulfilling an advocacy role. Diaries were also kept and used as supplementary research tools.

The analysis of the data demonstrates the ways in which nurses interpret their own practice world as a system independent of their own actions. It shows how the shared understandings of the participants were 'ideologically frozen' and power relations inherent in the health care system are deep rooted and subtle, coming to be treated as natural by the nurses, and so denying them their own ability to make changes.

It is suggested that opportunities for nurses coming together and engaging in such critically reflexive dialogue may provide a basis for future emancipation from traditional power structures. In this way effective and satisfying nursing practice dependent on emancipatory knowledge and a reinterpretation of power structures may result in an advocacy role for nurses.

PREFACE

In New Zealand the practice setting of nurses is mainly derived from a medical model of health, with nurses defining their work area as general medicine, or orthopaedics or psychiatry for example. Nurses, therefore, have become entrenched in rigidly defined institutional structures which, despite recent changes to nursing education and to health service management, have remained under the control of the medical profession and bureaucratic regimes.

Nursing has generally been viewed as a practical profession and until the mid 1970s, in New Zealand, the only opportunity nurses have had to advance their knowledge has been to undertake clinically based practical courses. These have been developed from the various medical specialties, with doctors acting as the principal 'lecturers' of nurses undertaking these courses. In this way, nursing has remained firmly under the control of medicine which has dictated the course content. At the same time the nurses undertaking these courses have provided a ready supply of cheap labour for the clinical area concerned.

However, with increasing tertiary education programmes for nurses at all stages of their careers, there has been an heightened awareness amongst nurses of the scope of their profession. As a consequence of this, some nurses are

resisting traditional roles and have been redefining their sphere of practice in the clinical setting.

The specialist field of gynaecology has recently been described as an area with an historically strong male domination (Coney, 1988). However, like nurses in clinical practice, consumers in this area are reacting to the strong medical domination and are currently demanding more say in their own care and treatment.

There is therefore a potential for change in this clinical area, to a partnership of nurse and consumer with the nurses assuming the role of advocate for the women who are clients of the service. Although the concept of advocacy has been loosely accepted as an integral part of nursing practice, the extent to which nurses can fulfill this role has been largely unresearched.

This study aims to fill some of these gaps by seeking to engage nurses employed in a specific gynaecological setting (an abortion clinic) in self-reflective inquiry. The purpose of this study is to improve the nurses' understanding of their social practices, the rationality and justice of these practices and the situations in which they are carried out. Nurses may then assume an advocacy role for those women who are the clients of this clinical area.

ACKNOWLEDGEMENTS

It is a pleasure for me to acknowledge the people who have enabled me to begin, sustain and complete this thesis.

The participants in the study, especially 'Alice' whose vision for nursing is a worthy goal, I would like to thank for making it all possible. Their time and enthusiasm was greatly appreciated, and I wish them happiness in nursing.

As thesis supervisor, Judith Clare earns my gratitude for encouraging me at all times and her balanced, honest feedback on every aspect of this thesis has helped me clear my vision. Her detailed assistance in times of panic has been indispensible to the production of this thesis.

To Joss, Louise and Di who 'made it' with me to the end of the first year and lived to tell the tale, a special thanks for all their interest and support. I hope their own research ventures go well. Bronwen who has proof-read the document, and found my many mistakes has been of great assistance. Thanks, Bronwen. Margaret and Gordon have fed and housed me in my many trips to Palmerston to complete this thesis and their friendship and company, at these times has been much appreciated.

Lastly I would like to express my very special thanks to Edna who has put up with me and my moods throughout the whole endeavour and kept me on the straight and narrow.

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CHAPTER ONE

Abortion Services in New Zealand

In common with other countries in the western world, nursing practice in New Zealand occurs mainly in formalised structures within clinical areas which have been defined by medical specialisation. In order to examine nursing practice, consideration must be given to the socio-political context in which it occurs. This study was undertaken in the general context of gynaecology and more specifically an abortion clinic, an area which carries highly emotive and political overtones. Before beginning to interpret and critique the practice of nurses who work in such an area, it is necessary to consider the abortion service in New Zealand.

This chapter begins by examining this aspect of women's reproductive health in New Zealand, prior to the 1977 Contraception, Sterilisation and Abortion Act and the abortion service currently available. Then an overview of the providers and users of the service will be presented, and some of the current political arguments on the subject discussed. Since there is no consistent definition of abortion in New Zealand that used throughout this thesis will be 'the induced termination of pregnancy before the fetus is considered viable.'

Development of Health Services for Women in New Zealand

The colonisation of New Zealand 150 years ago has led to the creation of distinct masculine and feminine cultures (James & Saville-Smith, 1989). In early colonial society, women had few legal rights, married women being considered subordinate to their husbands in all matters. This included reproduction, the conjugal rights of husbands being considered inviolable, and fathers having the sole legal responsibility for their children. The legalising of abortion in 1896 (to save the mother's life) was the first step in the enormous struggle which was to take place this century for women's control of their own fertility.

The history of women's health services in the twentieth century has been told in two different ways (Arney, 1983). Histories concerned with medicine speak of the scientific discoveries of the profession and how these discoveries were utilised to provide the 'best possible services' for women and children. The fight by doctors and others to obtain 'free' health care for all with the 1938 Social Security Act has also been well documented and Gordon (1958) speaks of her unfailing work to establish huge obstetric and gynaecology hospitals which would allow women access to the latest technology.

By contrast, feminist writers describe this process as the medicalisation of women's health and this, too, has been well documented internationally (Rich, 1976; Ehrenreich & English,

1979; Oakley, 1980; Bunkle, 1988). These writers have generally attributed medicine's success to organised, political thinking by its practitioners. Political action by doctors can be traced to the origins of the profession in New Zealand. Unlike the United States where, for example, 'regular doctors' had to compete with traditional healers, doctors were encouraged to emigrate to New Zealand where a new society was being created (James & Saville-Smith, 1989).

This was in the late nineteenth century, when the only competitors were the traditional 'untrained' midwives and Maori healers. Science was on the ascendency, however, and to prove its superiority over these groups, medicine showed that its knowledge was rigorously 'scientific' (Ehrenreich & English, 1979) and so by right could be the only legitimate healing profession. In this model of science 'knowledge' was obtained from medical lore, experimentation and analysis according to strict scientific criteria. Human experience became objectified and 'women's instincts,' which had often guided health practices was relegated to the home.

The male dominated medical profession was thus ideally poised to control reproduction arguing that their knowledge, increasing in the light of new scientific discoveries, was for the benefit of women and society generally. Women were excluded from the creation of knowledge vital to the control of their own bodies, and instead became the instruments by

which domestic order could be imposed on men and children (James & Saville-Smith, 1989).

The medical profession, having attained this position of power early in the colonial history of New Zealand, sought to retain this by organising themselves into a forceful political organisation. The New Zealand Medical Association was founded in 1893, initially as a branch of the British Medical Association, as the professional body responsible for the maintenance of standards of health in this country. This body still speaks collectively for medicine and has remained very powerful in representing medicine as a unified strong profession.

Medicine, supported by the church, their traditional ally for over three centuries (Smith-Rosenberg & Rosenberg, 1981), worked towards maintenance of the domestic role of women, by extending the principles of science and instrumental reason to the operation of the household (Reiger, 1985). Women were, therefore encouraged to remain home and 'breed'.

Gradually, doctors came to control all aspects of reproduction and when the 1938 Social Security Act was passed it 'won' all women the right to 'free' medical care in their pregnancies. To have babies was, therefore, seen as women doing their duty for the young country. As James & Saville-Smith (1989) say, women tended on the whole to accept this as

the natural order of things and the underlying ideology remained unquestioned.

Freire (1972) explains this unquestioning acceptance in terms of oppression where the oppressed internalise the image of the oppressors, adopt their guidelines and follow prescribed behaviour patterns. This prescribed behaviour represents the imposition of the oppressors' choice on the oppressed. The consciousness of the oppressor transforms everything surrounding it, including human life, into objects of domination.

Medicine, with its knowledge being rooted in the empirico-analytic paradigm of science, achieved this oppression in its treatment of women. Women's bodies as machines could be used for experimental purposes in the interests of furthering science (Foucault, 1973). All births, for example, like all machines, had the potential to break down and therefore the potential for pathology. Reproduction could only be managed by a doctor possessing 'expert' knowledge (Bonham, 1982).

This medicalisation of reproduction into obstetrics and gynaecology was described by medicine as being 'in the interests of the patient'. Freire (1972:44) describes this eagerness to possess as:

> the conviction that it is possible for them to transform everything into objects of their purchasing power, hence their strictly materialistic concept of existence. Money is the measure of all things and profit the primary goal

Feldstein (1973) argues that organised medicine has played an important role in profit abuse which is far from new. While the New Zealand Medical Association would deny this, saying instead that they have fought for the accessibility of the health care system to all women and described the achievements of medicine in reducing maternal and neonatal mortality, these claims have been refuted by modern feminist writers such as Daly (1978); Spender (1981) and, in this country, Coney (1988). The theory of innate female sickness, in which medicine 'scientifically proved' that female functions were inherently pathological was skewed so as to account for class differences in ability to pay for medical care (Lovell, 1980).

This has helped to maintain New Zealand's mix of public and private health care systems in which a gynaecologist may work two tenths with the public hospital 'as a service', but in reality, using this time to ensure that he will have access to the facilities of his choice for 'his' patients when they are admitted in labour. Even though this relationship is sweetened by false generosity, it remains oppressive to women because it does not allow for their subjectivity. Women become commodities to be used, pawns to be manipulated, at the whim of medicine.

In order to maintain this relationship, which has been described as one of symbiosis (Lovell, 1980), and prevent

subversion the oppressors must constantly control the oppressed. This perpetuates a cyclical hegemonic process, in which the more covert control exerted by the oppressors, the more the oppressed are inanimated and the more control is required. To these notions of control and power may be added the further dimension of deception. Bok (1979) sees deceit as a subtle control because it employs belief as well as action. The power of the deceiver coerces the deceived by a process of oppressive violence, which objectifies and dehumanises individual experience.

Deception can be accomplished through action or inaction and the most common form of deception practised by the medical profession is silence. Freire (1972) refers to this as one of the more powerful tools of oppressors - the culture of silence. Controlling and withholding information can be powerful tools of paternalistic deception. Again, there are medical claims of benevolence and concern for the deceived (Ehrenreich & English, 1979). The deceived client is once more dehumanised and amenable to the control of the doctor.

Ehrenreich and English (1979) describe this as 'expertism' which has provided for the economic and social triumph of male medical professionals. 'Knowledge' therefore becomes a commodity which may be 'sold', to clients who can afford to pay. Until recently it was only those women who could afford to pay who were able to procure abortion in New Zealand, from

either backstreet abortionists or selected gynaecologists, who classed the procedure as 'miscarriage'.

From these perspectives women were completely tied to men, both in the household and the health service. It has been through the ideologies of monogamy, domesticity and motherhood that women's fertility has been controlled, with sexual activity directed towards childbearing and rearing (Ryan, 1986). While these ideologies remain steadfast in New Zealand society today, the increased availability of contraceptives and abortion since the 1960s has led to some measure of sexual freedom for women. However, as Bunkle (1984) argues, much of the 'reproductive technology' available to women has neither been created by women nor is in the interests of women and so is another example of authoritative knowledge as a source of power.

Of course doctors do not act in isolation from society in general, and the process by which men and women come to define themselves and each other in terms of sex-role stereotypes is extremely complex. The education system, for example, plays a particularly important part in teaching boys and girls their respective gender roles (Middleton, 1988). Eisenstein (1984) points out that it is important to see the powerlessness of women as dialectically related to the sexual division of labour. It is clear, therefore, that capitalist 'welfare' institutions such as the health service have an

interest in bringing about and maintaining this powerlessness. Thus doctors become extremely important in defining not only what it is to be a woman but in controlling any woman who might attempt to cross these boundaries (Doyal, 1979).

Doctors, therefore, in New Zealand still wield considerable power and control, and as far as medicine is concerned, most women will seek the help of doctors to manage their pregnancies and future reproductive lives. Reproductive technology remains dominated by medicine and indeed the knowledge gap between doctor and patient has widened to such an extent that it has become increasingly difficult for women to make an informed decision between different methods of contraception, most of which require a prescription from a doctor. Patriarchal ideologies, reinforced by medicine, continue to exercise social and political control, through influencing the consciousness of women to accept its world view.

This control by medicine has meant that despite the increased availability of contraception since the 1960s, women have still not been able to fully control their reproductive health. The very meaning of the term 'family planning' associated birth control within the context of the nuclear family, and doctors often permitted their 'clinical freedom' to decide to prescribe or not prescribe contraceptives at

their choice.

Development of abortion services in New Zealand

With increased availability of reliable contraception in the 1960s, some doctors predicted (McFarlane, 1972) that there would be a corresponding decrease in the number of abortions being performed. Historically, abortion had been 'legal' in New Zealand since 1896, on the grounds that continuing the pregnancy posed a danger to the woman's life, though the Indecent Publications Act (1910) stated that drugs, medicines and methods for procuring abortion were deemed indecent.

The vagueness of the law was the overriding feature of the next 80 years and proponents in the arguments both for and against abortion took advantage of this. The Medical Association supported by an anti-feminist backlash came out strongly against abortion in the 1920s, and in the 1930s New Zealand had the second highest maternal mortality rate in the world (Brooks, Tims, Dawson, Hirst, McIntosh, Penhale, Routledge, Trim & Church, 1981). This figure included "an abnormally high death rate due to septic conditions following on attempts to procure abortion" (Brooks et al:29).

A special committee was set up by the government in 1936 to investigate the 'abortion problem'. Their findings were inconclusive but recommendations were directed towards increasing family benefits and obstetrical help. These

recommendations were drafted into law with the passing of the 1938 Social Security Act.

No changes to the law on abortion were recommended at that time and it was to be another 25 years before parliament once more considered changing the abortion laws. With the redrafting of the Crimes Act in 1961, sections 182 -187 were specifically concerned with abortion, but once again the status quo was retained with the law remaining as stringent as ever. That is, where a viable fetus was concerned, only danger to the woman's life constituted grounds for legally inducing abortion. Again the law was so vague that there was considerable variation in its interpretation.

'Legal' abortions were being performed in increasing numbers in public hospitals by gynaecologists who accepted women referred by their general practitioners, assessed them, and if they considered the procedure justified, performed the operation. This culminated in 1974, with 1008 abortions being performed in public hospitals (Royal Commission, 1977). In May 1974, Auckland Medical Aid Centre was opened specifically to perform 'legal' first trimester abortions.

The early 1970s was also the era of opinion polls on the subject of abortion (Facer, 1977). Polls were carried out both locally and nationally, by large research organisations and abortion again featured on the political agenda. The

debate became heated, with those campaigning for liberalisation of the abortion laws on one hand and anti-abortion societies being founded on the other. The most active of the latter groups was the Society for the Protection of the Unborn Child (SPUC) founded specifically to fight the abortion issue. Based on Roman Catholic principles, this organisation had a series of eminent gynaecologists as presidents and patrons, and commanded considerable following.

Finally a Royal Commission was set up by the government in 1975 charged with investigating current practices of contraception, sterilisation and abortion throughout the country and determining future needs. The two most powerful members of the group, the chairman and the doctor were known conservatives. Submissions were received from a variety of sources but according to Brooks et al (1981) valuable lessons from overseas were ignored. Once again the main theme of the report of the Royal Commission (1977) seemed to be preservation of the nuclear family and control of women's fertility (Ryan, 1986).

The recommendations of the Royal Commission (1977) were to become the basis of the 1977 Contraception Sterilisation and Abortion Act, which legislated for the provision of licences for abortion and the supervision of the licensees. It, again, was aimed at the control of the procedure rather than

assisting women towards choices. The need for two consultants to determine the justification for abortion, together with the stringent licensing provisions meant that the Auckland Medical Aid Centre had to close and once more there was a rise in the number of 'illegal' abortions being carried out.

It was to be some time before the first abortion clinics were established in New Zealand, but following the passing of the 1977 Act, women requesting abortion, whose general practitioners considered met the criteria defined in the Crimes Act (1961), could be referred for counselling in this country. Abortion Counselling was carried out by a group of women known as Sisters Overseas Service, who set themselves up in the main centres, providing trained counsellors for women to see, if they desired. They also assisted those who were accepted for abortion in Sydney to make travel and accomodation arrangements, though women were required to pay for these themselves.

The present day abortion service in New Zealand

An amendment to section 187 of the Crimes act (1961) legalised abortion if it fulfilled at least one of the following conditions:

- Continuing the pregnancy would result in serious damage to the life, physical or mental health of the woman.
- There is a high risk that if born the child would be severely physically or mentally handicapped.

The pregnancy is the result of incest.

The woman is severely subnormal in terms of the Act.

The Royal Commission (1977:213) rejected rape as grounds for abortion as they believed "that the inclusion in any legal code where pregnancy resulting from rape is a ground in itself for abortion would for the very few women which it would benefit be the subject of abuse". The law was generally seen to be a victory for the conservatives but as Oakley (1983) says, even where appropriate legislation exists there is no guarantee that doctors will interpret it to mean that the pregnant woman's wishes should be respected.

The 1977 Act contains a clause entitled 'conscientious objection' in which no doctor, nurse or other person shall be under any obligation to perform or assist in the performance of an abortion. The doctor's personal moral values are thus given the title of 'clinical freedom' and so the right to control women's lives remains firmly with the dominant ideology. As Weisman, Nathanson, Teitelbaum, Chase and King (1986) say, it is the attitude of practising physicians that will determine the availability of abortion. In some American states this is unacceptable and where abortion is unavailable women's groups have trained lay women as 'abortionists' in order to provide a service which they see as a necessity. In New Zealand this has not happened, though there are areas which have recently been reported in the

daily newspapers as needing an abortion service urgently.

In New Zealand, despite the clinical freedom of the medical profession, the state, rather than medicine, ostensibly provides the control on the service by means of the Abortion Supervisory Committee. This three member taskforce is appointed for a term of three years as a condition of the 1977 Contraception, Sterilisation and Abortion Act. However, in regard to this committee, section 10 of the Act states that "not less than two shall be registered medical practitioners". Allsop (1984) describes this as further subtle subversion by the medical profession in an attempt to meet its own ends, and dominate the practice of health care in both the public and private health care institutions in this country. As Friedson (1970) says, by driving a wedge into other zones of practice and maintaining control over facilities, all the work done by other related occupations is subject to the orders of the doctor.

> The (medical) profession alone is held competent to diagnose illness, treat or direct the treatment of illness and evaluate the service. Without medical authorisation little can be done for the patient by para-professional workers.
>
> Freidson, 1970:141.

Doctors, therefore, through the state and the Abortion Supervisory Committee are seen to hold legitimate power which serves to maintain the patriarchal capitalistic society, with its emphasis on the nuclear family which is still considered the 'norm' in New Zealand today.

Users of the service

The Abortion Supervisory Committee's report (1989) shows that in 1988 the number of induced abortions performed at the licensed institutions was 10044 (12.7 per thousand women in the 15 -44 age group). While this represents a rise of over 1000 abortions from the previous year, the New Zealand figure is still one of the lowest when compared to other 'low fertility' countries. The Act further distinguishes between 'women' and 'girls'; most abortions are being performed on 'women' aged between 16 and 29, but only 2.06% on 'girls' under 16 years. Over 9000 abortions were performed because of 'serious danger to mental health'.

The consistently low percentage (21.3) of married women obtaining abortions appears to support the Royal Commission (1977) view that a married woman in a 'harmonious relationship' is more likely to accept the child of her pregnancy even if the pregnancy was unplanned. However, such statistics do not tell if the woman has decided to accept the child or if she has approached her general practitioner for an abortion which has been declined.

The official statistics do not, however, classify the women according to 'race'. Local statistics held by abortion facilities provide this information and it is interesting to note that the numbers of Pacific Island women obtaining abortions is on the increase while that of Europeans and

Maori is fairly steady. Various Pacific Island groups have expressed concern about this in the news media (Sunday Star, July 1, 1990) and are to run education programmes with the intention of reducing this number.

The percentage of Maori women obtaining abortions remains consistently low and this is supposedly reflective of a cultural belief that abortion is unacceptable. However, Maori history (Gluckman, 1976) suggested that, unlike Pakeha women, Maori women traditionally controlled their own reproduction and made decisions concerning contraception and abortion. It is perhaps a sign of the male medicalisation and dominance over reproduction occurring since colonisation that has led Maori women to describe abortion as culturally unacceptable, preferring instead to adopt within the family. It is a source of concern to some Maori, however, that Maori women who do obtain abortions are largely unsupported, as the pressures of their families would make the procedure impossible. A recent paper by the Maori Women's Welfare League (1990) expresses some of the current concerns and outlines strategies for Maori women seeking abortion in the future.

The current political debate

Not only are women subject to the control of the state and the medical profession, but since the founding of SPUC in 1970 a strong anti-abortion lobby in this country has also

vied for control. SPUC, containing a large proportion of health professionals has consistently fought to prevent any abortions being carried out in New Zealand. Since its inception, it has maintained the pressure, by attempting to petition members of parliament and set up counselling services for pregnant women as an alternative to those provided by institutions which carry out abortion. Churches are generally also anti-abortion, but because they consider themselves 'apolitical' encourage their members to join organisations such as SPUC.

SPUC, Women for Life and other minority groups also are responsible for maintaining a vigilance outside abortion clinics throughout the country and in the setting studied, representatives of the group were present in 'peaceful protest' every day. The peaceful protests mainly take place just off the premises and involve stopping women attending the clinic, suggesting that there were alternatives, and handing out literature featuring glossy pictures of babies. Placards, mainly of a christian nature were also in evidence. Protesters said that they did not have a high 'success' rate but even if they stopped one woman 'murdering her baby' it would be worth days of standing outside in the rain (personal communication).

Occasionally, protestors follow women on to the premises. On these occasions, the police are called and the protestors

charged with trespass, if they do not leave when asked by a member of staff. One man has served over a year in gaol due to his 'calling' to save these women and babies.

A new group has recently emerged which poses more of a threat to both women attending the clinic and staff who work there. This group known as 'Operation Rescue' is an international organisation, again based on the christian principle of preservation of life. This group aim to stop all abortions by effectively blockading access to buildings. Their protest action takes three phases, the first is a group prayer meeting, the second, individual counselling of anyone trying to pass their baricades and the final in occupying the premises. While new to New Zealand in 1990, this group has successfully stopped operations in Wellington, Auckland and Christchurch on more than one occasion. This group has been condemmed by both feminists and SPUC.

Such is the intensity of feeling on both sides of the abortion debate, however, that feminist groups are now lobbying for liberation of the country's abortion laws, saying that abortion should be freely available to all women and that women should not be subjected to judgements by others based on their own interpretation of the Act. In addition, the Royal Commission's recommendations that women should not have to travel too far to procure an abortion have not been upheld. As yet, there is nowhere on the west coast

of the South Island that provides an abortion service and the Area Health Board of the Manawatu/Wanganui region which carries a large population is still debating the issue. In the meantime, women from these regions and others are still having to be referred out of their area, thus contributing to waiting lists in regions where the service is provided.

The Auckland Hospital Board (1987) at one stage refused to accept women from out of the Auckland/ Northland area saying that women were having to wait in some cases till they were 13 or 14 weeks gestation. This led to longer, more time consuming procedures, so perpetuating the problem. It was, the board declared, good for no-one and was expensive, therefore was draining other services of necessary resources.

The debate continues and is likely to do so for some considerable time as it represents such a sensitive issue. Whether, the Act is amended towards a more or less liberal interpretation, it remains the women who utilise the service that are directly affected by the ideological positions held by the influential players on both sides. Women, therefore, continue to be used for political gain.

Nurses' practice in abortion clinics

Finally in this chapter, the position of nurses in the provision of the abortion service is discussed. The dominant nature of medicine exerting its subtle but far reaching

controls has already been discussed, as has the central nature of counselling in the present day service. However, before specifically discussing nursing, it is interesting to consider the medical and social work disciplines in the clinical setting.

While controlling the organisation of the country's abortion services from 'behind the scenes', in the clinical area studied, doctors do not have a high profile. Indeed, for an area which was open for nine hours per day doctors were present for only about four. Their principal duties were to sign the approval form and to carry out the operation, a procedure which takes on average, five minutes. For each case they are currently paid $150.00 in addition to their salary paid by the Area Health Board.

On the other hand counsellors are highly visible, adopting the role of primary care giver. This has remained unchanged and basically unchallenged since the pre-licensing days when they operated the Sisters' Overseas Service. The Act stated that a counselling service must be available to all women and that a social worker must supervise the counselling service. The present day service has developed with this central focus on counselling. While general practitioners remain the primary point of entry to any hospital service in New Zealand (Scott, Fougere and Marwick, 1986), counsellors appear to be the primary point of entry to abortion clinics. Women are

initially seen by counsellors, who take charge not only of counselling, but contraception, and clerical duties. Social workers employed by abortion clinics believe that counselling should only be undertaken by them and that this should be mandatory (Nicol, 1987).

The Act's stipulation that for each abortion carried out, there must be consent by two certifying consultants, one of whom must be a gynaecologist generally means that counselling is carried out in tandem with one of these appointments (Nicol, 1987). The gynaecologist seeing the woman after her counselling appointment is able to take into account their assessment when deciding whether this woman is suitable for an abortion. In the interests, therefore, of obtaining what they want, i.e. an abortion, women generally do not question the need for counselling despite the 'soul searching' that they may have undertaken, prior to visiting their general practitioners.

Counsellors are all qualified social workers or are working towards this qualification. Their duty appears to be carrying out a social assessment on every woman and accompanying her throughout the procedure. They do not challenge the medical dominance of 'the system' and their work is routinised.

Nurses, in this setting, have historically carried a role

subservient to that of counsellors. The first nurses appointed were often part time staff nurses who were specifically to work in theatre. They were responsible directly to senior nursing personnel of the local base hospital, who made it very clear that the role was to 'assist' in theatre and nothing else. As the service grew, so did the number of personnel of all disciplines including nursing. Nurses were allowed to work in theatre and recovery, and finally assisted the doctors by taking the women's medical history.

This limited scope of practice of nurses has ensured that medical dominance manifest through the counselling service remains the rule. The gender hierarchies in which male dominated medicine ranks superior to nursing and other health professions are unchallenged (Webb, 1985). The area itself is a gender construct, 'gynaecology' being part of the division of women's health resulting from the 'scientific' discoveries of medicine. Nurses therefore, like the women clients of the service are controlled by the medical profession, even if these controls are not overtly displayed.

With an increased knowledge base, however, nurses are no longer tolerant of this situation, where nursing knowledge is all but invisible (Benner, 1984; Hickson, 1988) and nurses' positions are low on the hierarchy. Nurses are seeking new challenges, in the light of their new knowledge (Smyth, 1986)

Nurses working in an abortion clinic have elected to work in the area, because the Act allows those who are unwilling not to work there. Nurses, therefore, feel that they have knowledge and skills which would enable them to work for the women, providing support and assisting in decision making, rather than acting as doctors' assistants. In her report on the cervical cancer inquiry, Cartwright (1988) specifically commented on the subservient role of nurses and their apparent inhibition by the power of the medical profession.

This research therefore considers an expanded role for nurses, that of client advocates. In the following chapter the concept of advocacy in relation to nursing practice will be examined to provide an overview of the extent to which nurses have been able to fulfill this function.

CHAPTER TWO

Nursing and Advocacy

Health care today, with its emphasis on new technologies and treatments can create an arena fraught with many ethical dilemmas. One of the most complex of these to confront nurses, over the last twenty years, is the extent to which nurses should fulfill the role of client advocate. The concept of advocacy first appeared in the International Nursing Index in 1976. Since then, the published literature on the subject has been prolific, but before this time, nurses writing in the field of 'patient education' have also contributed to a growing body of literature relevant to this topic. The aim of this chapter is to critically examine and challenge some of the assumptions which underpin advocacy, as outlined in nursing and other relevant literature, and determine which models, if any, could be utilised by nurses practising in the study setting.

What is advocacy?

In examining the nature of advocacy, it is important to consider some of the usages of the term in the English language. The Collins English Dictionary (Guralnik, 1980:11) defines an advocate as one "who pleads another's cause especially in a law court". Advocacy, at this simple level, is a role that has existed for as long as there have been

people in less powerful positions who need someone to 'plead their cause'. Although in use since the fourteenth century, according to Thompson & Thompson (1981), advocacy has developed in the western world in conjunction with the expansion in technology and the growth in democracy which have been features of the twentieth century. With increasing job specilisation and professional knowledge, the idea of advocacy has come to be embraced by those other than the legal profession.

The need for advocacy in the health services

Spectacular advances in the 1960s in medical technologies have seen the development of new drugs, sophisticated machinery and perfected techniques (Bates & Lapsley, 1985). This has enjoyed enormous success, but has also received much criticism, both on the grounds of improper evaluation and its dehumanising impact (McKinley, 1984). As Johnstone (1989) says, medical technology becomes morally troubling when its use or non-use does not agree with the recipient's rational preferences and health goals. It is here, therefore, that serious questions may arise concerning the rights and interests of clients of health services.

It is not merely in the areas of high technology that there are questions regarding the rights of clients. As Abrams (1978:259) states:

> The need for a patient advocate is generally thought to emanate from the unfortunate but inevitable physical and psychological state of being a patient as well as the overwhelming complexity of the hospital structure.

She continues by describing the picture of a 'typical' hospitalised patient as experiencing loss of autonomy and initiative and the transformation from activity and responsibility to passivity dependency and obedience. Gillette (1988) suggests, in relation to women's health care that as gender stereotypes require a woman to be passive and submissive; when she is hospitalised this must become doubly so, as she adopts the sick role. This combination, she believes, leads to a loss of control effectively limiting a woman's ability to stand up for herself so indicating the need for an advocate.

Nursing and advocacy

Since the inclusion of 'advocacy' in the International Nursing Index, an abundance of nursing literature has attempted to define or describe advocacy, provide a rationale for the assumption of the advocacy role in nursing or promote a specific model of client advocacy (Donahue, 1985). The importance of client teaching, education and counselling has also been well addressed (Wilson-Barnett, 1983; Close, 1988). Nevertheless, there is a great diversity of opinions regarding acceptable definitions of these terms. Given this, it appears obvious that although in common use, the concept of advocacy is not well understood or supported.

Despite its popularity in the nursing literature the majority of the literature is non-research based, much consisting of philosophical reflection and opinion. While this provides an intellectual basis for advocacy, there is little literature which examines how client advocacy has been operationalised in practice (Wilberding, 1984). As Johnstone (1989) says, one of the main weaknesses in nursing's argument for assuming this role is that insufficient attention has been paid to establishing sound philosophical bases for both the concept of advocacy and the role which is derivative of it.

An examination of nursing definitions of advocacy reveals a wide range of views in which the common factor is the client herself. The main themes that emerge include support, self-determinism, human rights and information giving. Some authors (Curtin, 1979; Gadow, 1980) go as far as to say that advocacy forms the very philosophical basis of nursing and the role of advocate is crucial in the provision of humanistic health care. Others (Kohnke, 1980) suggest that before nurses can adopt this role it is vital that advocacy be taught in all nursing courses.

Advocacy was viewed by Christy (1973) as the nursing challenge of the 1970s. This would involve nurses acting as patient sponsors, supporters and counsellors (Donahue, 1985), and would be achieved through the acceptance of new

responsibilities, the development of a deeper understanding of the broad definitions of nursing, the acceptance of accountability and the collective group becoming social activists.

Fay (1978) believes that implicit in the definition of nursing practice is the notion of advocacy, and she describes activities that could be incorporated into curricula to enable students to understand the concept through experience. She believes that this is necessary as most nurses are women who have been socialised to be passive and submissive, so practice is necessary in speaking for their clients. Sawyer (1988:29) supports this position saying:

> a nurse-patient relationship is a special one based on giving and taking, need and response. The basis of caring is cooperation and co-responsibility.

This type of relationship will inevitably lead to the nurse advocating for the client, in helping her to reach her own decisions. Like Fay, she acknowledges the need for formal education on the subject if the nurse is to successfully fulfil this role.

Storch (1978) also supports this position as there are a large number of nurses distributed throughout the health care system who have sustained contact with the client and family members. This, she believes is consistent with the 'traditional' role of the nurse. Certainly the early nurse-leaders were advocates being "concerned about and committed

to human rights, dignity, humanitarianism and accountability" (Donahue, 1978:146).

However, just as there is much written in support of the advocacy role for nurses, there have also been authors who question the appropriateness of nurse for this role. Jenny (1979) for example, viewed the observance of clients' right as producing a conflict of interest between those providing the service and the clients. Abrams (1978:265) also questions the nurses' suitability for this role by suggesting:

> that a possible conflict exists between the advocate's role of representing the patient's wishes and the nurse's role of always acting in the best interests of the patient.

Porter (1988) believes that the nearest nurses can come to patient advocacy is some form of benign paternalism within a capitalist health care system. McFadyen (1989:47), also speaks of lack of power of nurses which leaves them in a weak position as advocates, who "may be forced to accept compromise based on sympathies directed towards a flawed care system".

In New Zealand, the concept of nurses as advocates was raised at the 1988 cervical cancer inquiry, when the commissioner commented that nurses had largely been invisible, both during the time that experiments had been carried out on women in hospital, and also at the time of the inquiry (Cartwright, 1988). In her ruling she felt that while nurses should be

the advocate for the patient, they generally felt too intimidated by medical staff and for this reason could not be relied on to be effective in this capacity (Cartwright, 1988). 'Patient advocates' are now being appointed around the country who are 'independent' of the organisations employing them and so are not expected to hold divided loyalties.

It is obvious, therefore, that there is not total agreement concerning this role for nurses, and due to the limited published research available on the subject, it is unlikely that consensus will be achieved in the near future. Research based material for the most part focuses on the nurse's giving of specific information (Wilson-Barnett, 1978; Webb, 1983) or the effect of nurse's counselling of clients (Kreuger, Hassell, Goggins, Ishimatsu, Pablico & Tuttle, 1979). Pankratz and Pankratz (1974) carried out a study which attempted to measure nurses' attitudes concerning autonomy and advocacy, reporting that 'positive' attitudes correlated with advanced education and nontraditional clinical settings. It is clear that additional studies are required in this area.

Models of advocacy

Perhaps the most important outcome of the discussion on advocacy in the nursing literature is the description of the models of client advocacy that have been proposed. Donahue

(1985) questions the effectiveness of these models as true advocacy or merely stop gap measures to solve immediate problems. She suggests that an advocacy model for nursing would need to consider long-term or projected outcomes, which would focus on the client becoming her own advocate when possible. Several writers, however, have moved beyond this 'stop gap' notion to propose models of advocacy which will now be considered in relation to the setting of the abortion clinic outlined in the previous chapter.

Abrams (1978) has described five models of client advocacy which taken together, could incorporate a broader view of the concept and provide some flexibility for nurses in assuming this role. These five models include a counsellor, adviser, client's 'rights' advocate, representative and monitor. While related, each of these models has slight differences especially in regard to the ethical implications for both the nurse and the client. Abrams describes a counsellor as one whose function is:

> the alleviation or reduction of fear, consolation, re-establishment of feelings of autonomy and self-control, recognition of one's feelings, and finally, but not of least importance, companionship and attention.
>
> Abrams, 1978:260.

The main theme of this model is the informing of the client. Nurses would fulfill this role from their initial meeting with the client, as they orientate each new client to the area. As Gillette (1988) says, the focus here is on

environmental mastery rather than assisting the client to be self determining. In the abortion clinic the process is seen by doctors and managers of the health services in terms only of a 'minor' operation and so is scheduled to take place in the quickest possible time. The 'counselling' undertaken by nurses in this model could only be directed at informing the women, as to what would be 'done to them' during their hospital stay.

This is the role currently adopted by 'counsellors' in abortion clinics in New Zealand and the lack of emphasis on participation by the client severely restricts its usefulness. For nurses adopting this model of advocacy the images of loyalty and obedience are reinforced (Nelson, 1988). Problems could exist for clients in that limited information may be given.

The second model suggested by Abrams is that of adviser. Here, the advocate would discuss alternative therapies or treatments in order to help the client decide on a suitable option. In this model, the client assumes a much more active position, thus it is more congruent with the aims of the women's health movement. In hospital settings, a barrier to this has traditionally been the control by doctors over the 'right' to inform patients about medical care. Here 'alternatives' are limited in that they remain under the control of the medical profession. Nurses have assumed a

subordinate position and as Buckenham and McGrath (1983) and Hickson (1988) discovered, registered nurses saw their main function as assisting and supporting the doctor. Gillette (1988) suggests that there is some hope that nurses will be in a position to become advisers in the near future, because of the move of nursing education away from a medically dominated environment, to tertiary education institutions.

In a freestanding abortion clinic, the viability of the adviser model is doubtful, however, not for the reasons discussed above, but because of the nature of the work. The Royal Commission (1977) recommended that abortion counselling be carried out independently of the institution where abortions were themselves carried out. This was not, however, incorporated in the Act. Had it been, nurses could have adopted the model of adviser, helping the woman to make decisions concerning the continuation of her pregnancy. As Nicol (1988) found, usually by the time women come to the abortion clinic they have already made up their minds what they want and prefer to get it over with as soon as possible. It therefore becomes the function of family or friends to act as adviser when the woman first discovers she is pregnant.

A third model proposed by Abrams is that of 'representative' in which the advocate would be a spokesperson for:

> those classes of patients who cannot speak for themselves, namely, some patients in emergency situations, the comatose, the mentally ill and children.
> Abrams, 1978:261.

Because of the nature of the socialisation of women and the subsequent way health services for women have developed in New Zealand, it may be argued that nurses, being mainly women are in a strong position to understand the needs of women and speak on their behalf. However, there is a potential here for abuse of power, and this has happened with the medical profession who have previously assumed the right to speak on behalf of their clients. This has become a major argument of writers who have suggested that the nurse is not the best person to act as client advocate (Porter, 1988; McFadyen, 1989). Abrams herself sees difficulty with this model if the advocate acts paternalistically on the basis of a personal decision. Like the counselling model, it does not specifically address issues such as self-determination and sharing (Gillette, 1988).

This model of advocacy has also been proposed by social workers (Abramson, 1989; Gibelman and Demone, 1989). However while it challenges the assumption that nurses alone can assume the role of advocate, the same difficulties are inherent in this model regardless of who assumes the advocacy role.

Abrams also suggests a monitoring model. Here the advocate's job is to ensure that the client is receiving the best possible care. Quality assurance programmes have assumed this function, but the standards of these have again been set

by the organisation concerned and do not provide for alternatives. Some client participation is included but is generally restricted to answering questionnaires. Experience has also shown that while nurses are keen to embrace quality assurance, doctors have treated it with disdain, and their powerful status thus prevents this model from being very effective. Again, the nurse must consider whether her loyalties are to the client or to the organisation.

The final model proposed by Abrams (1978:261) is that of 'patient's rights advocate'. This she describes as an "information provider and 'watchdog'". This could be limited by merely ensuring that all clients had access to the 'code of rights'. This was the approach adopted by the Auckland Area Health Board (1989) following recommendations of the cervical cancer inquiry (Cartwright, 1988). However, given a broader interpretation, this model seems to be all encompassing of the other four models, and I believe that it has the potential to move from such a narrow interpretation to provide the means of change in the health care system.

A client's rights advocate implies more than simply informing women what will 'happen to them' when they become clients of the health care system. The advocate in this model acts to ensure that clients' rights are respected and intervenes when they are not. One of the major criticisms of the health service by the women's movement has been the treatment of

women as dehumanised objects who are unable to actively participate in their health care (Rich, 1976). This model, therefore, is consistent with the aims of the women's health movement.

Nurses, practising in a nursing framework, see 'person' as a central component, therefore those who accept this model will operate from the basic assumption that persons (clients) do have certain basic rights. Adoption of this model would provide nurses with the opportunity to assist clients to participate in an informed way their own health care decisions (Gillette, 1988).

This form of advocacy has also been described by Kohnke (1980) who suggests that advocacy is to inform and support the client, ensuring that she has sufficient information upon which to base her decisions. Kohnke (1980) warns nurses, however, that advocacy is very much a learned skill, involving an acquired role. She emphasises that nurses will have to decide if they want this role, and if they want the client to have all the information. In situations where power has been closely guarded, nurses may find it difficult to share this power with those in their care. Nurses, according to Kohnke, must also understand what it will mean for the clients to have the information and must be prepared to put personal biases aside.

Webb (1985) has suggested that in the instances of women having abortions in gynaecological wards nurses have been unable to fulfill the advocacy role. The feelings and biases of nurses and the pressures on those who work in this setting have been well documented (Char & McDermott, 1972; International Council of Nurses, 1977). Despite this, little has been written concerning the nurse-client relationship where this is positive.

In New Zealand the 'conscience clause' permits nurses to opt out of caring for women undergoing abortions. In freestanding abortion clinics, nursing staff are working there of their own accord so should not be biased against the women attending. That nurses are working in abortion clinics through personal choice does not necessarily imply the role of advocacy. However, by respecting the rights of the clients of the clinic, nurses have already begun to assume the second component of the advocacy model that Kohnke (1980) describes, that of support.

Here, supporting is distinguished from informing, by describing this phase as 'assuring' and 'reassuring' clients that they have both the right and the responsibility to make their own choices without giving into pressures from others. Like Abrams, Kohnke warns that nurses in this phase of the relationship should not fall into the trap of subtly undermining decisions that conflict with their own.

Curtin (1979:3) in presenting her model of advocacy, states that she rejects the patients rights view of advocacy, proposing instead the concept of 'human advocacy' based on "our common humanity, our common needs and our common rights". She believes it is this common humanity that compels nurses to accept human advocacy as the philosophical foundation of nursing. The emphasis is on the uniqueness of each client which will be recognised by the nurse who may spend sustained periods of time with them.
The nurse-advocate will then create an environment that is open to and supportive of the individual client's decision making.

Curtin's notion of human advocacy as a 'natural' nursing role does contradict Kohnke, who insists that it is an acquired role. However, it does not appear to differ greatly from the idea of 'human rights advocate' proposed by Abrams, or the two phase process of informing and supporting described by Kohnke. In critiquing Curtin's work Johnstone (1989) states that Curtin has failed to recognise that client rights are merely a subcategory of human rights and nothing can be gained by distinguishing between them.

Gadow (1980) has continued the 'humanity' theme with her model of existential advocacy. Like Curtin, she ostensibly rejects the notion of 'patients rights advocacy' which she

describes as similar to the counselling model of Abrams. She also carefully distinguishes it from the concept of paternalism. Like the client's rights model, however, she believes that nurses should do more than insist on a 'code of rights' and should, instead, assist individuals to exercise their freedom of self-determination. She describes nursing advocacy as:

> the participation with the patient in determining the personal meaning which the experience of illness, suffering, or dying is to have for that individual.
> Gadow, 1980:87.

Like Curtin, Gadow fails to distinguish between human rights and client rights as if the client is something other than a human being. Yet she discusses at length, the idea of individual autonomy and the need for a coming together of the value systems of the nurse and the client to enable the client to make autonomous decisions. This appears identical to the 'patient's rights' model of advocacy proposed by Abrams.

The future for nurses as client advocates

While the various models of advocacy discussed suggest a role that could be adopted by a variety of people, I would support the idea of nurses fulfilling this function. In the past, however, as noted by Cartwright (1988) nurses have been reluctant to undertake this function. The socialisation of nurses in the past, and which still exists to a certain

extent, has led to nurses assuming a function secondary to that of the medical profession. Curricula of nursing education programmes have in the main been developed from medical and technological perspectives (Perry, 1985a) and so nurses have until recently not been willing to abandon the image of nurse as 'ideal woman' and doctor as 'ideal man' (Watson, 1977).

To enable nurses to adopt an advocacy role, therefore, requires a dramatic shift in thinking in the nursing profession as a whole as well as its individual practitioners. With many basic nursing education programmes currently undergoing curricular revision, attention should be given to the necessity of preparing nurses for this role. In the abortion clinic, the intimacy associated with the process would also lend itself to a minimum of personnel being involved with the client. With the broad base of nursing education combined with the careful selection of nurses for this setting nurses would be the appropriate persons to act as advocates.

It appears, then, that despite Gadow's and Curtin's declared rejection of a client's rights model the difference is merely in semantics and this model of advocacy is most appropriate for nurses working in abortion clinics. The definition proposed by Gadow (1980) emphasises the human to human relationship and the 'informing' and 'supporting' described

by Kohnke (1980) outlines the main functions of the nurse-advocate. It is therefore this definition which was chosen by the participants in this study, as an appropriate aim for their practice. The remainder of this chapter considers the practical implications of such a role.

The educational role of the nurse-advocate

The idea of informing clients is not new to nurses. Indeed the literature on 'client education' dates back to the 1950s. While it was not developed to any great extent at this time published articles focused mainly on the client as a passive recipient of information with no part in the decision making process (Nahm, 1952; Beck, 1958). This trend was to continue with information being given to assist the client to acquire certain skills (Curtis, 1961; McAntee & Peddicord, 1987).

Informing clients in this manner, however, is a practical task based upon the idea of technical application of 'educational knowledge' for the purpose of attaining a given end (Van Manen, 1977). While it may have been openly stated that the aim was to 'provide' the client with more knowledge, there is a hidden agenda of ensuring their compliance.

'Knowledge' when applied in such a manner, is derived from behavioural psychology which in turn is rooted in empirico-analytic science, with central features being order and control. Knowledge is therefore controlled by the

professionals who decide what and how much information will be transferred to the client. The rigid and pre-determined boundaries of this paradigm appear to be the antithesis of the proposed model of advocacy, therefore to base the 'informing' phase of the relationship in this framework is self-defeating.

To allow for the high level of client participation necessary for the proposed model of advocacy to succeed, this view of education must be rejected and instead consideration given to alternatives which may be more appropriate for creating and communicating ideas. Humanistic theory which evolved many years ago in the Ancient Greek civilisations, was the basis for most tertiary education programmes up till the middle of the last century.

Concerned at the increasing dominance of empirico-analytic science, Dewey (1916) made an attempt to revive humanism by suggesting that if education should be conceived of as the process of forming fundamental dispositions, intellectual and emotional, towards nature and fellow men then philosophy may be defined as the general theory of education. However, it was not to be till the 1970s that humanistic theory rooted in the works of Carl Rogers and Abraham Maslow underwent a revival in education and nursing practice.

Humanistic education is therefore existential in nature and

emphasises freedom of choice, values and individual integrity. Informing clients from a humanistic perspective, however, is only beginning to be recorded in the literature pertinent to client education. In this paradigm, although discrete, informing and supporting are complementary to each other. The concepts of humanity and personhood are central (Paterson and Zderad, 1976). Knowledge is seen in this model as a social product which has to be negotiated, and the meanings of situations are explored between the teacher and learner. Each person's experience is important and contributes equally to the relationship in which information is disseminated through mutual exploration of meanings (Stanton, 1988).

The client, in this framework is central to the process of learning and the distinctions between teaching and learning become blurred (Reagan, 1980). The role of the nurse in this setting is more as a facilitator, who encourages and assists the client to focus on key aspects of material and discover relationships between new and previous knowledge (Byrnes, 1986). The relationship of the nurse and client is thus more of a partnership, in which each can learn from the other.

This philosophy has great potential for client education programmes for the future. In settings where primary nursing is practised, for example, the nurse and client have the opportunity to 'come to know' the other and by so doing can

start to explore some of the areas of concern to the client. The nurse and the client are each acknowledged as active subjective human beings who interact with each other to form a relationship and so actualise the potential of the client (Paterson and Zderad, 1976). Knowledge derived from intuition and experience of the nurse is recognised as legitimate in this paradigm (Benner, 1984) and forms the basis for autonomy of both the nurse and the client, where autonomy is compatible with the recognition of human interdependence (Grimshaw, 1986). It becomes an opportunity to acknowledge the clients responsibilities in maintenance of her own health.

Education conceptualised from such beliefs moves away from the focus on measurement, instead relying on inference and subjective evaluation in which growth may be maximised rather than attaining a minimum standard (Byrnes, 1986). Nurses now and in the future could work with their clients towards developing education programmes in this paradigm with a view to creating a partnership in which learning and growth become the central foci.

There is still a danger of nurses adopting paternalistic attitudes in this framework, however:

> as the knowledge which is generated promotes a self-awareness and seeks to promote a self critical but not necessarily socially critical form of inquiry.
>
> Perry, 1985b

For the nurse, this again means that loyalty to the

organisation might dominate her views while for the client seeking an abortion it is her socialisation as a woman that will limit her experience and subsequent self-determination. While knowledge is gained about the subjective interpretation of each client's situation, the nature of the structural forces acting upon them may not be uncovered and hence the problem remains.

To be client advocates nurses must carefully consider the structural constraints surrounding them and which may have prevented them fulfilling this function in the past. This study seeks to uncover some of these constraints in order that the goal of advocacy may be achieved by nurses in the clinic. The theoretical background which will provide the basis for this study will be discussed in the next chapter.

CHAPTER THREE

Theoretical Background.

Before attempting to develop an analysis of the ideologies which have allowed social patterns affecting nursing practice to be taken for granted and, more specifically, the degree to which the nurses in this study assume the role of client advocate, it is necessary to first examine theories which offer critique of societies, and emancipation of the dominated groups. This chapter presents an overview of such theories which have provided the basis for this study, and discusses their strengths and weaknesses, through the consideration of theoretical concepts which are used in the later analysis.

Power

Traditional approaches to the concept of power commonly have a behavioural focus, in which the issues of power and control become inseparable. Several of the most influential writers on power describe power as synonymous with control. For example French and Raven (1959) identified five bases of power as expert power, reward power, coercive power, legitimate power and referrent power.

With expert power the 'powerful' are seen to possess superior knowledge and information. Knowledge is seen as an object to be possessed by the powerful and then shared to a limited

extent or withheld completely, so providing the basis of power. Reward and coercive power are similar in their intent and are frequently encountered in organisational settings, where the powerful have the ability to reward or punish the subordinates. Likewise, legitimate and referrent power have a certain similarity in that holders of legitimate power may prescribe certain behaviours in others thus leading to the creation of the concept of referrent power.

It is the adoption of bases of power such as these on which the medical profession has come to develop its dominance over the health services for women in New Zealand.

Power, Knowledge and Control of medicine

In chapter one the historical dominance of medicine over women in the development of abortion services in New Zealand was explored. Medicine, like other dominant groups in western society, has established 'expert' power through validation of its theories by empirico-analytic science. By means of rigidly controlled experimentation, medicine has accrued a vast knowledge of the disease process. Since, in medicine's view, disease is seen as the opposite of health medicine has proclaimed itself as expert in the health field. Expert power is therefore tied to scientific knowledge which is treated as an object to be possessed by the 'knower'.

Because the holders of this power consider themselves

expert, those who perceive themselves as less powerful are generally compliant. They come to trust the institutions and the 'experts' within them, as the legitimate source of knowledge. It is within the interests of the holders of power, therefore, to distance themselves from the less powerful, by increasing the knowledge gap, and so continue the right to dominate.

The power of the medical profession has further been manifest by its ability to give rewards and withhold resources. This is demonstrated in today's health services by medicine's control over, for example, waiting lists and the spending of large amounts of money. The nursing profession, despite much larger numbers and much greater client contact have little say over such matters. Ashley (1980) describes this power of the medical profession as one manifestation of patriarchal society in which misogyny keeps women oppressed in subjugate, domestic roles, living out the cult of 'true' womanhood.

While power described in such terms is generally indicative of the relationship of the medical profession to health services for women in New Zealand there are several limiting features in the model. Clegg (1977), for example, has criticised the formulation of bases of power because of their 'dehumanising' nature. He believes that the acceptance of such explanations of power do not explain how some people have access to the resources while others have not.

Bachrach and Baratz (1962) support this view arguing, by this focusing on bases of power, the deliberate suppression or overlooking of issues by dominant groups within organisations can be obscured. The subjugation and coercion of minority groups may thus be ignored, as roles within the organisation are defined and patterns of authority and professional relationships routinised. For the nurses who participated in this study, their work tended to be seen as a routinised series of actions, prescribed by the 'institutional culture'.

Such classifications of power are therefore limiting, not only for the above reasons, but also for their a-priori nature, and their lack of historicity. As Giddens (1979) states, with approaches such as this, structure and human nature tend to be simplified into a dualism, whereby one aspect is either ignored or assumed. Lukes (1977) suggests an alternative approach, more cognisant with the approaches taken in this study in which:

> social life can only be properly understood as a dialectic of power and structure, a web of possibilities for agents, whose nature is both active and structured, to make choices and pursue strategies within given limits, which in consequence expand and contract over time....No social theory merits serious attention that fails to retain an ever-present sense of the dialectic of power and structure.
>
> Lukes, 1977:29.

This is similar to the views held by Bordo (1989) who believes that in the realms of femininity an analysis of power 'from below' is needed. With such a power the central

mechanisms are not repressive but constitutive; " a power generating forces, making them grow" (Foucault, 1978:136). When considered like this, power will allow women to confront the mechanisms by which they become enmeshed, colluding with forces which sustain their oppression (Bordo, 1989).

Hegemony

Where the initial view of power outlined above is accepted there is a tendency for it to become legitimised by western society as, according to Lukes (1974), people are prevented from having grievances by the powerful who shape their views. Positions in the existing order are accepted either because they are valued or they can imagine no alternative. Social practices based on these values and beliefs are reinforced and maintained by the ideologies inherent in that society.

Where this occurs, the ability is provided for the dominant group to exercise social and political control in such a way that their modes of thought come to be seen as the only possible way. The concept of hegemony as described by Boggs (1976:39) explains how this may occur:

> Hegemony in this sense might be defined as an 'organising principle' or world view (or combination of such world views) that is diffused by agencies of ideological control and socialisation into every area of daily life. To the extent that this prevailing consciousness is internalised by the broad masses, it becomes part of 'common sense' as all ruling elites seek to perpetuate their power, wealth and status, they necessarily attempt to popularise their own philosophy, culture, morality etc. and render them unchallengeable, part of the natural order of things.

Hegemony, therefore, perpetuates and maintains existing beliefs and values of individuals as well as perpetuating social practices and institutions (Apple, 1979)

According to Perry (1985a) it it through such a process of socialisation into the institutional culture, that registered nurses learn to think and act in ways which have been defined for them by others. This relegates their function, in the health services, to that of mere technicians (Apple, 1982). Historically, nursing has been controlled by medicine and the medical model of 'health' has dominated both nursing practice and nursing education. Most registered nurses today tend to practise within frameworks that have been dictated by advances in medical technology, ensuring that nurses experiences are controlled by rules and regulations, resulting in standardised care within organisations.

An ideology suitable to maintain the position of the powerful side thus comes to dominate, shaping thoughts and actions in line with its norms. The differentness of the weaker side is interpreted by the stronger as inferiority, so compounding the hegemony.

The concept of hegemony is not a static force, however, as according to Gramsci:

> a social form always has marginal possibilities for further development and organisational improvement, and in particular can count on the relative weakness of the rival progressive force as a result of its specific character and way of life. It is necessary for the dominant social force to preserve his weakness.
>
> Gramsci, in Simon 1982:38.

Hegemony, therefore must alter according to the social conditions and expectations of the time.

The fact that the medical profession is traditionally comprised of males adds a further dimension to the nurse-doctor dichotomy. The concept of 'hegemonic masculinity' (Connell, 1987) illustrates the complex nature of hegemony within the health care system, which not only creates and perpetuates the subordination of women as nurses and clients, but also may divide men amongst themselves. Connell sees hegemonic masculinity as the force behind the centre of power relations and processes acting to retain the "collective project of oppression" (Connell, 1987:185).

The above discussion, however, does not mean that the medical profession will maintain their dominant position without a struggle: hegemony is a transient concept which must first be won then worked at to maintain. While struggle and resistance are possible, one way in which hegemony may be countered is that of 'ideologie-critique', in which consciousness raising is employed to show that power relations are not the natural order of things but are the

creation of the dominant culture. This is one of the main differences between critical social science and other forms of science.

Critical social science

Although critical theory does not mean the same thing to all its proponents (Held, 1980), there is a certain unity of purpose in that the central task of theory is to emancipate people from the positivist domination of thought through their own understandings and actions.

Geuss (1981) identifies three major distinctions between scientific and critical theories:

(1) The goal of science is to manipulate the external world, while critical theory aims for emancipation and enlightenment.

(2) The cognitive structure of science is objectifying while critical theories are always, in part about themselves.

(3) Science requires confirmation through observation and experiment while critical theories must be reflectively acceptable.

Critical theory, therefore, is not only a school of thought but also an immanent process of critique of social reality with the aim of transforming rather than maintaining present systems (Giroux, 1983). Hence, as critical theorists engage

in the process of theorising, new ideas are constantly being invoked according to the interaction between theory and subject.

However, despite differing ideas, according to Fay (1987) there is one major aim of a critical theory and that is to redress a situation in which a group is experiencing deep but remedial suffering as a result of the way in which its members' lives are arranged. To achieve this, means overturning these arrangements by replacing them with another set in which people can relate and act in fuller, more satisfying ways.

Fay (1987) describes a critical theory as a complex of theories which are systematically related to one another. A fully developed critical theory would comprise four key theories:

(1) A theory of false consciousness, which demonstrates how human beings have come to be constrained by ideological forces which guide their everyday understandings and actions. It explores the historical context for these (mis)understandings and actions and their domination and finally, acknowledges the capacity of these human beings for self reflection and self determination to create an alternative superior self understanding based on rational action.

(2) A theory of crisis, which examines the expressed

dissatisfactions of the group in the light of its historical context and defines the crisis in relation to the false consciousness and unfree existence (Geuss, 1981).

(3) A theory of education. This brings to the agents an awareness of the coercive social institutions which have made them cling to their ideological world picture. It shows that transition is both necessary and possible and outlines the conditions necessary for enlightenment and emancipation, enabling agents to make choices consistent with their real interests (Carr & Kemmis, 1983).

(4) A theory of transformative action. This shows an acceptance of the interconnectedness of social theory and social practice, in that it asserts that the necessary transition can only come about by way of acting in the critical theory (Geuss, 1981).

Critical social theory then, according to Geuss (1981:2), is "a reflective theory which gives agents a kind of knowledge inherently productive of enlightenment and emancipation." As Fay (1975) says, critical theory takes the stance that truth is partially determined by the specific ways in which scientific theory is supposed to relate to practical action. In this study such a "self sustaining process of critical analysis and enlightened action" (Comstock, 1982:387) aims to increase the awareness of the particular group of nurses to the contradictory conditions of their actions which may be distorted or hidden by everyday understandings. The belief of

critical social science is that these nurses are active agents in the construction of their practice world rather than objects of the socio-historical process. By the acceptance of these beliefs, this research invokes the concept of reflexivity as a means of "protecting it from the researcher's own enthusiasms" (Lather, 1986:268).

It is the recent works of the German philosopher, Jurgen Habermas, in philosophy and sociology which have recast the notion of critical theory as a product of and serving the purpose of human action (Craib, 1984). Like earlier critical theorists, Habermas was concerned with exposing the ideological character of empirico-analytic sciences. Habermas (1974) saw the danger in the dominance of this one dimensional ideology as producing an exclusively technical civilisation devoid of any connection between theory and praxis. His reconstruction of classical philosophy is based on the inseparability of truth and virtue, facts and values, theory and practice. Habermas believes that the aim of critical theory is to further the self-understandings of social groups capable of transforming society. This, he suggests, may be achieved through a process of reflection and analysis of the connections between knowledge and human interests (Habermas, 1972).

Nursing knowledge.

The epistemological theory of cognitive interests resident in all forms of knowledge is a key concept of Habermas' critical theory. The notion of 'technical knowledge' in relation to the power of medicine has already been discussed.
It is this technical knowledge however, that has largely formed the basis of nursing education and practice.

Habermas (1972) believes that this form of knowledge arises out of a human interest in technical control, with the structure of knowledge being intimately related to the principles of social and cultural control in a society. Throughout the twentieth century medicine has managed, through strict adherence to technical curricula, to maintain such controls over nursing practice.

As Lovell (1980) points out, nurses are allowed new experiences, but the limits of these continue to be strictly defined by medicine. This may be seen in the clinical field as new advances in medical technology are introduced to all clients on the grounds of 'client safety'. In nursing education, there is pressure on educators to 'train' nurses for this real world, so medicine and the technical curricula continue to dominate here, too. This approach to education has been criticised by Freire & Shor (1987) who describe it as the 'transfer of knowledge' approach, suggesting that its primary aim is to maintain the dominant ideologies of society

which sustain elite authority.

It is not to say, however, that nurses do not have self interest in working within this framework. For example, to register as a nurse, students still have to pass an examination set by the Nursing Council of New Zealand, first having satisfied the head of the nursing department of their educational institution that they are 'fit and proper' to register. To achieve this standard it often is simplest and safest for their educators to work towards stated objectives, which are congruent with the Nursing Council's requirements.

Habermas (1974) describes a second form of knowledge related to practical interests. This knowledge emerges from human interaction and our mutual understanding of each other and has led to the development of hermeneutics as a science. It is concerned with making visible and understandable the experiences, actions and perceptions of the actors. It seeks to clarify meanings and assumptions and recognises the subjectivity of those involved. This is reflected in nursing practice and education with the development of humanistic nursing theories (Paterson and Zderad, 1976) and educational curricula (Bevis, 1986). Habermas, however, believes that people's understandings may be distorted by ideology, so this practical interest is limited.

The limitations of the technical and practical models give

rise to the development of a third form of knowledge, that of emancipatory knowledge. Emancipation is derived from the relentless critique of existing social conditions which maintain irrationality, injustice, social fragmentation and domination, to reveal systematically distorted communication and action (Carr & Kemmis, 1983). The logic of predictability, seen in the empirico-analytic paradigm is replaced here by a dialectical mode of thinking that stresses the historical, relational and normative dimensions of knowledge.

This social dimension of knowledge is also stressed by Freire (1972) who sees knowledge as an active task of subjects rather than being passively acquired by unmotivated 'objects' of education. Freire believes that knowledge cannot be separated from the personal, social and political interests of the 'knowers'. Knowledge, therefore, has the potential to be emancipatory.

Habermas' construction of emancipatory knowledge is based on the assumption that through a process of reflection and rational analysis people can understand, empower and emancipate themselves. It is this idea of empowerment and self-transformation which gives rise to Foucault's (1973) contention that power is the medium in which emancipatory knowledge is generated. He argues that power and knowledge are thus inseparable and to have one implies the other. It

is because this relationship has been disguised that power has been seen as oppressive and hiding its own mechanisms. For Foucault, emancipatory knowledge raises the question of how power is to be exercised.

This positive linking of power to emancipatory knowledge has not been widely explored in relation to nursing practice. Speedy (1989) however, suggests that emancipatory knowledge would empower oppressed nurses to view their situation in relation to the surrounding, dominant structures. Hickson (1988) believes that such knowledge could feed into radical critique of existing structures which surround the social world of nurses. By developing this awareness it would provide a way of showing the oppressed how to initiate alternatives, leading to changes in the relationships of power.

For the nurses participating in this study, the process of developing emancipatory knowledge would involve their critical reflection on their own situation in relation to the development of abortion services in New Zealand as well as to their desired advocacy role. 'Reflectiveness', for these nurses, would involve the evaluation and re-evaluation of their own beliefs and values concerning their nursing practice in relation to new evidence uncovered in the research process. It is this constant self-reflection and re-evaluation which will enable these nurses to engage in a

conscious process of initiating alternatives, leading to their emancipation.

Habermas' (1972) analysis of knowledge shows that what is described as 'science' by positivists, is simply one particular form of knowledge which is reflective of the interests of the 'knower' at a particular point in history (Faraganis, 1989). To Habermas' categories of knowledge, a further dimension is added when consideration is given to the fact that nursing is mainly a woman dominated profession. The recognition that epistemological assumptions are politically based (Hawkesworth, 1989) has provided some means of expressing women's views as legitimate 'ways of knowing'. The intuitive actions of 'expert' nurses (Benner, 1984) which cannot be explained in terms of reason and rationality may become instead the basis for philosophical discourse.

Nursing knowledge, then, may be grounded in politics, history and gender and once this is recognised, utilitarian questions emerge, in particular, how is this knowledge used? Is technical knowledge which supports the status quo dominant, or does the development of emancipatory knowledge alter power relations in the nursing world? Is nursing knowledge used to enter into a partnership with clients in which the nurse assumes an advocacy role?

In asking these questions, science may be seen as a form of

discourse, subject to definitions of terms, delineations of rules and formulation of canons as to what counts as knowledge and authority (Faraganis, 1989). Habermas (1974) believes that discourse is the only way of redeeming claims of truth and correctness of emancipatory critique.

Discourse.

In seeing science as a discourse, a form of speaking about the world, the critical social scientist can deconstruct the traditional relationship between positivism and power. Traditional discourse, according to Freire & Shor (1987) will confirm the dominant, mass culture, but by engaging in liberatory dialogue the critical social scientist will affirm the freedom of the participants to re-make their culture.

Within discourse, the participants will seek to problematise their experiences, searching for arguments in the light of mutual recognition between different individuals. Validity claims, ordinarily implicit in communication are rendered explicit with the sole view of arriving at a mutual understanding. According to Habermas (1974) these understandings are reached by a process of 'argumentation', which makes possible the continuation of communicative action when disputes arise. These understandings will be reached only if sufficient time and openness is given to the process of argumentation so that the conditions of that truth may be met.

This type of discourse presupposes the ideal speech situation (Habermas, 1974) in which all participants have the freedom to engage and participate in discourse in such a manner that no repressive dominance, asymmetry or inequality exists (Van Manen, 1977). Agreement, in this situation, is reached on the basis of superior reasoning and not by means of any form of coercion or domination. While Habermas acknowledges that there are very few if any situations that permit this ideal speech situation, it serves a useful, purpose in the identification of patterns of systematically distorted communication.

The ideal situation with the aim of rational consensus is often prevented from occurring by pre-existing patterns of thought which have not been fully acknowledged. This builds on the Marxist notion of ideology in which attitudes, beliefs and values embodied in social practice serve to retain the status quo.

It is such ideology which systematically distorts communication to the extent that a group may assume they they have freely arrived at a genuine consensus, when in reality, pre-existing beliefs and values have prevented them from communicating effectively. The practice arena of nurses is saturated with many beliefs and values, some of which have been outlined in chapter one, which have led to the dominance

of medicine and subservience of nursing.

For nurses to become emancipated from this domination, they must locate their self-understandings in their historical, political and gendered roots, in order to uncover the processes by which these understandings may have become systematically distorted, through the actions of the dominant group. It is by this process that nurses may engage in ideologie-critique of their practice, with the aim of undertaking transformative action.

Implications for the research

As described by Fay (1987), critical social science with its commitment to autonomy, enlightenment and emancipation provides a firm theoretical background for the research process. In this study, this consists of critical dialogue between researcher and participants, who will engage in a process of joint discovery and illumination, of the structures which have historically dominated and constrained nursing practice.

Limitations of critical social science

Although critical social science overcomes many of the limitations of methodologies related to positivistic and phenomenological sciences and provides a unique basis for exploration and critique of society, theorists developing this scholarship have been criticised for its idealistic

nature. Fay (1987) argues the case both for and against critical social science, and Lather (1986) points out that even although a theory may enlighten it does not necessarily result in emancipation. However, as Geuss (1981) argues critical social science does have the potential to emancipate and this is all that is required. For nursing, then, this tradition holds considerable promise for its emancipation from traditional structures.

In the following chapter the methodological approach adopted in this study is outlined. Links between this methodology and the theoretical basis outlined above will be described and explored in this next chapter.

CHAPTER FOUR

An Emancipatory Research Process

As argued in the previous three chapters, the New Zealand Health Care System is dominated by medicine. This means that in order for nurses to become advocates it is necessary to make considerable changes to their practice. One way to do this is to engage in a research process which focuses on enlightenment and emancipation. This chapter, therefore, outlines the research process based on the critique of society which is used in this study.

Emancipatory methodology

It has been argued that emancipatory paradigms of research are both theory and method (Perry, 1985a). Kreugar (1981:59) however, believes that despite the interest in critical theory there are "hardly any attempts at the development of an alternative methodology in the sense of an 'emancipatory' social research." Lather (1986) supports this and concludes that such a social science would allow us not only to understand the maldistribution of power and resources underlying society but also to change this in the interests of achieving more equity. She later develops this idea further (Lather, 1988) and states that an emancipatory social science must be premised upon the development of research methodologies which empower the researched to both understand and change their world.

As discussed in the preceding chapter, critical theory with its emancipatory intent offers a powerful basis for critiquing the status quo. Likewise, while feminist theory is multi-paradigmatic, when located within the critical paradigm, it also has the potential to maximise the research process as a change enhancing, reciprocally educative encounter. Research of this nature has been described by Lather (1986) as praxis orientated; that is, concerned with empowerment of the oppressed to come to understand and change their realities by informed, committed action.

Praxis has been described by Grundy (1987) as fundamental to the emancipatory cognitive interest. Praxis thus takes place in the real world, that is the social and cultural world of the people. According to Freire (1972), the key concepts of praxis are action and reflection, with the aim of making social and political changes. For praxis to be possible, theory must not only illuminate the lived experience of the people but also be itself illuminated by their struggle (Lather, 1986). Praxis, therefore, implies a reflexive relationship between theory and practice in which each builds on the other (Grundy, 1987).

Carr & Kemmis (1983:165) point out:

> praxis has its roots in the commitment of the practitioner to wise and prudent action in a practical situation. It is an action which is informed by a 'practical theory' and which may, in turn, inform and transform the theory which informed it.

The practitioner is therefore central to praxis-oriented research as only the practitioner has access to the commitments and practical theories which inform praxis. As Lather (1986) points out, the intent of emancipatory research is to enable the participants to understand and change their situation. A methodology accepting of the self-determination of the participants is important, therefore, as it is this which would consciously aim to enable these participants to critique their existing situations as a basis for their self-transformation.

The idea of emancipatory research based on the cyclical process of action and reflection beginning with the problems of the participants, gives the participants the power to recognise the contradictions inherent in social understandings and specifically seeks to locate counter-hegemonic practices at work (Giroux, 1983). This concept of the cyclical process which is central to emancipatory, praxis oriented research has led to my choice of action research as the methodology for this study.

Action Research

Action research is a term first defined by Lewin around 1946 who described the process in terms of planning, fact finding, execution and analysis. Lewin described the process as a cycle, which, because action research is an ongoing strategy, is repeated and reformulated (Tripp, 1990). This process has

since been termed as a spiral which, according to Tripp (1990) implies open ended movement rather than the closed system of the cycles. It is the naturalness of this spiral of 'moments' that leads people to see action research as something done by any practitioner all the time and totally lacking the necessary artificial development that characterises scientific research.

Lewin's concept of systematising, naming and describing processes common to everyday life, has given rise to action research which is both apolitical and atheoretical. Such 'research' has been used by health service managers (Cope, 1981) as a basis for change. However, according to Carr & Kemmis (1983), while most modern researchers recognise the limitations of Lewin's work, three important characteristics of modern action research were identified; its participatory character, its democratic impulse and its simultaneous contribution to social science and social change. It is this emphasis on democracy and social change which relates to the idea of emancipatory research outlined above.

Emancipatory action research according to Carr & Kemmis (1983) incorporates a social perspective which recognises that individuals are part of an environment in which there are unjust power relations and practices. It stimulates a social response to those constraints which limit change to a

level considered 'acceptable' by the ruling elite and aims at transformation of the organisation and practice therein, rather than simply the adjustment of individuals.

Central to emancipatory action research, therefore, is the view of society as being essentially unjust, but capable through praxis of becoming less so. This is achieved through the Lewinian spirals of planning, acting, observing and analysing. Each of these 'moments' of the action research spiral is dependent upon the others for the success of the research and it is generally considered that a single application of the loop degenerates into a mere problem solving exercise.

In this study, the spiral begins with a general reconnaissance of the field. Planning then considers prospective action, which, conversely is retrospectively guided by planning. The planning moment of the spiral will begin to identify some of the key values embedded in the lifestyle and aspirations of the participants. It will also identify some of the constraints perceived by the participants as having a detrimental effect on their practice. Once values and constraints have been identified these may be used as a basis for the action moment of the first spiral. Action, however, may occur independently of planning; this is a risk inherent in this methodology. Observing is again prospective, it has the function of

documenting the effects of action with the intention of providing a sound basis for critical self-reflection (Carr & Kemmis, 1983). Finally, analysis is retrospective, looking back at the problems and constraints made visible through planned, purposeful, strategic action.

It is this combination of retrospective and prospective moments of action research that distinguishes action research from problem solving or everyday planning. The planning and analysis moments of the spiral encourage discourse amongst the participants, while the action and observation moments link this with practice. It is important, therefore, that each of the four 'moments' are not seen as static steps complete in themselves. Together, they give rise to research that is intrinsically critical:

> it aims to improve practice on the basis of a critique of practice, and to improve understanding on the basis of a critique of understanding, and to improve the practitioner's situation on the basis of a critique of the situation. Carr & Kemmis, 1983:165

Emancipatory action research is seen as collaborative in nature. The selection of the participants in such a project is vital to the success of such research and this issue will be considered next.

The research participants and setting

The participants selected for study were an opportunistic group of registered nurses who worked together in a

freestanding abortion clinic, funded by an Area Health Board. I was approached by the group who wanted to make some changes to their nursing practice, but needed some assistance. I was personally known to all the group members, having worked with most of them on various projects over a period of about three years. As this study was to be based in the unique experiences of this particular group, no attempt was made to obtain a sample representative of a larger population.

Having met with the group to discuss some of their concerns and being unable to give them immediate answers, we discussed the possibility of turning their expressed concerns into an action research project. Response from the group was initially favourable so it was agreed to wait until all the preliminaries associated with such research had been undertaken, before further discussions would take place.

Following these preliminaries, the participants were contacted and invited to attend initial discussions. All agreed to these meetings which were held at the researcher's house in off duty time. Prior to these meetings all potential participants had the opportunity to study the research proposal. The purpose of the research and the nature of the research process were more fully described at this preliminary meeting and each nurse was given the opportunity to ask questions and express concerns. It was explained that as this was a collaborative study their input

would also be valuable in writing the next draft of the proposal.

I felt that it was important to hold these preliminary meetings on an individual basis, despite the proposed collaborative nature of the study. Each participant had to feel comfortable within herself about her participation, rather than agree because of peer pressure. At the end of this meeting, verbal consent to participate was obtained; this was later followed by written consent to participate and accept the use of a tape recorder to record interviews. It was emphasised that this consent was not a binding contract, rather it was for the protection of both parties and withdrawal from the study was possible at any stage of the research process. Seven out of the eight nurses agreed to participate.

Prior to commencing the planning phase of the first action spiral, one further meeting was held with the participating group. This group consisted of six staff nurses and a nurse manager. Five of the group had been employed in the area for over three years, the remaining two for less than one year.

At this stage some of the characteristics of collaborative research were outlined, particularly the relationship between the researcher and the participants. My stance was that of an 'outsider' in the sense that I did not work in the

area concerned. However, over the preceding years I had come to know the group through their association with the In Service Education department of the base hospital to which they were affiliated and where I had previously worked. It was this association which led to their initial approaches to me, so from the perspective of knowledge of the participants and the practice setting I may have been initially considered an 'insider'. The geographical distance, however, which separated me from the group made it impossible, I believe, to be a complete insider; instead we concentrated on aiming to achieve a maximal approach to reciprocity by negotiation of description, interpretation and principles (Lather, 1986).

Tripp (1989) suggests that the key characteristics of reciprocity are:

(1) a shared commitment to the necessity of the research

(2) the research agenda concerns topics of mutual concern.

(3) control over the research process is equally shared.

(4) the outcomes are of equal value to all participants in professional terms.

(5) there is fairness and justice amongst participants.

While it was accepted that the degree of importance of the research would vary amongst participants including the researcher, all agreed that it was meaningful. An interactive approach was vital to involve all research

participants in the construction of meaning and the validation of knowledge.

The subjectivity of the research participants was clearly acknowledged, as we aimed to work together through a process of dialogue to encourage self-reflection and deeper understanding of the social situation of the professional world of the participants.

Interviews

In addition to the preliminary interviews already described, four group and three individual interviews were carried out with each participant. These interviews did not adhere to a set of structured questions but rather reflected the nurses' concerns within the broad focus of the research. The interviews were therefore conducted in an interactive, dialogic manner requiring self disclosure from both the researcher and the participants.

The interviews took place over a six month period, with some participants speaking informally with the researcher on the telephone or by letter between times. These interviews corresponded to the planning, observing and analysing moments of the action research spiral, with action occurring continually, during this period.

Since the research was a collaborative venture, the planning moments of the action research spirals occurred solely in the form of group interviews, with all the participants present. These group interviews lasted from one to three hours with all participants contributing to the discussion. Initially, as the researcher, I found that the other participants were looking towards me to see if they were saying 'the right thing' but as we warmed to our subject this feeling disappeared. While some participants were more vocal than others, all had valuable contributions to make to the project.

Observation and analysis also formed part of the group interviews, but after the initial interview concentrating on the 'planning' phase it often became impossible to distinguish between these three moments of the spiral, because with observation came analysis, and analysis of one action was frequently the planning of the next.

Individual interviews were used to supplement the group discussions. Again these were generally unstructured though focused and lasted from 30 minutes to one hour. Apart from the preliminary interviews, which had occurred first, these followed group interviews and the participants were always very keen to offer their opinion on progress. Individual interviews focused on the observation and analysis phases of the action research spiral. As each participant observed and

described her own practice world, through her experiences, she joined with the researcher in analysing these experiences.

While individual interviews were recorded entirely on audio-tape, allowing comments to be placed more accurately in context during analysis, this was not always able to be done in the group sessions. The first meeting, after setting up and testing the tape recorder, we must have disconnected it resulting in a blank tape of a two hour session. To counter this each of us wrote a summary of our perceptions of the session and negotiated the meaning of this at the second meeting. The remaining group sessions were taped but this was switched off frequently as debate became heated or topics raised that might have been later regretted. The tape recorder was thus not a very satisfactory medium for recording group interviews.

For individual interviews, however, audio-taping did prove satisfactory, with participants each having the opportunity to study their own transcripts and make amendments as they wished. For the most part, these amendments consisted in clarifying statements they had made and which were further discussed at the next meeting. Key points of the interviews had also been noted by the researcher for discussion at the next meeting.

To supplement the information available in interviews each participant (including the researcher) was asked to write down any thoughts she might have that were relevant to the study. Five of the participants did this, the remainder 'forgetting' or being 'too busy'. The data obtained from this was mainly related to the observation and analysis phases of the spirals, and served as a direct link between the interviews and the action. These journals also reminded participants of issues they wanted to discuss at the next meting.

Ethical considerations

All research requires that the researcher undertakes certain procedures in order to maintain ethical standards. Prior to commencing this study the research proposal was presented to, discussed with and approved by members of the Massey University Human Ethics Committee. It was then submitted to the ethics committee of the local Area Health Board, but as it was not concerned with clients, they chose not to review it. Instead, permission for access was sought and obtained from the Divisional Nurse Manager of the affiliated base hospital.

The collaborative nature of emancipatory action research implies the affirmation of the rights of individuals to autonomy and self direction. This means that the researcher is under an obligation to ensure that these capacities are

not threatened. In addition the goals of empowerment and emancipation through action require that such research is openly interventionist. This further requires that the researcher ensures as fully as possible that the participants understand the nature of the research process and the intended outcomes of the study, in order that they are in a position where they may freely choose to participate or not.

In this study, this was achieved by nursing staff in the selected area first being given a copy of the research proposal followed by a verbal description of the proposed study as part of their regular ward meeting. Questions were invited and the relationship of researcher and participants explained as one of collaborative partnership. Assurances were given that the aim of the study was to focus on the potential role for nurses as the woman's primary advocate, not to evaluate individual nurses' performance in this, or any other role. This verbal description was followed up by a written information sheet covering the main points.

The first individual interviews, which took place with all staff, were not taped and involved a full explanation of the study. The degree of participation in time and nature was fully discussed and explained to the extent possible. Possible implications and outcomes of research of this nature were also discussed and it was emphasised that participants could withdraw from the study at any time without adverse

consequences. The negotiation of meaning continued as the study progressed, thereby ensuring that all participants remained fully informed.

It was further emphasised that taped interviews would be under the control of the participant who may stop the tape at any time. It was explained that tapes would not be accessible except to the researcher and her supervisor. Transcriptions of group interviews would be available for all group members to edit, confidentiality being maintained by the usage of initials, while transcriptions of individual interviews would only be available to the individual concerned and would be identified by a code name, chosen by the participants, again to appear in the final report.

In addition to the confidentiality of the participants, protection of the identities of the women who were clients of the clinic was also vital. As this research is concerned with the role of nurses rather than their interaction with individual clients no documentation referring directly to individual women would be viewed. Due to the intimacy involved with abortion and the need for one to one counselling no observation of nurse/ client contact was undertaken.

Issues of reliability and validity

Efforts to produce social knowledge that will advance the struggle for a more equitable world must pursue both rigour and relevance (Lather, 1986), because as Acker, Barry and Esseveld (1983) state, an emancipatory intent is no guarantee of an emancipatory outcome. The acknowledgement of subjectivity and personal bias, does not mean that emancipatory research should fail to connect methods with theory, indeed past efforts to limit all elements of subjective knowledge out of the research process have been seen as a contradiction in terms (Cronbach, 1980).

The concepts of reliability and validity thus need reconceptualisation if they are to sit comfortably within an emancipatory paradigm. They also require that researchers develop new techniques and concepts for obtaining and defining trustworthy data which allow critical examinations of the tensions and contradictions inherent in the research design. According to Lather (1988:576), it is such self-reflexivity which will lead toward a paradigm where issues of bias are no longer "canonised methods of establishing scientific knowledge."

The reflexivity of emancipatory methods involving dialogue between participants and researcher, who together theorise about the issues, implies a distinctiveness about each situation, therefore replicability is not compatible with

this paradigm. However, such reports provide an account and critique of the way in which the subjective understandings of the practice world are developed and maintained. By illuminating new possibilities for action, readers are offered a 'surrogate experience'. Identification of similarities and differences may allow readers to engage in critical reflection of the conditions of their own practice and so enhance the potential for action. There is therefore a continually evolving process, with constant potential for action.

The validity of emancipatory research and the critical theories produced within them are testable only in action (Hickson, 1988). Lather (1986) offers a reconceptualisation of validity which is more appropriate for research of emancipatory intent. First she considers a form of triangulation extended beyond the traditional definition of multiple measures, to include multiple data sources, methods and theoretical schemes. In this study, data from individuals was compared with that from the group and journaling was used to supplement interviews.

At all stages of the research, negotiation amongst the participants concerning the meaning of statements and propositions and refining this where appropriate, met the condition of face validity described by Lather (1986). Her third concept is that of construct validity. Self-

reflexivity of the participants to reveal how a-priori theory has been changed by the logic of the data becomes essential. It is the enhanced self understanding preceding political action that will test the construct validity of this research.

Lather (1986) also adds a fourth test of validity, that of catalytic validity, which represents the degree to which the research process reorients, focuses and energises participants toward knowing reality in order to transform it. The evidence of enhanced self-understandings preceding action, again may be seen as the meeting of this criterion. However, like construct validity, some of these effects are not immediately visible, but may become so with the passage of time.

Conclusion

This chapter has introduced the methodology used in this study and the participants involved and the process of obtaining the data, with due regard being given to ethical considerations. The following chapters present and analyse the data, and discuss some of the implications for nursing practice, as well as some of the limitations of the study.

CHAPTER FIVE

Data Analysis and Critique.

In this chapter, the data is presented and analysed in a manner which contextualises that information in such a way that the lived experiences of the participants in relation to the theories outlined in chapter three are foremost. While the planning, action and observation phases of each action research spiral are all crucial 'moments' of the research process it is the analysis of these moments that draws together the themes and threads in order that informed judgements may be made and the next loop of the spiral initiated. This chapter, therefore, presents only a brief summary of the planning, action and observation phases of the research. It is acknowledged, however, that at times there was no clear delineation of boundaries between each 'moment' of the research.

The participants' views of their nursing practice and potential for the future are illustrated with excerpts from both the group and individual interviews using the participants' own words wherever possible. In this way, I have endeavoured to give the reader a clear idea of what it is like to be a registered nurse practising in this freestanding abortion clinic and experiencing the constraints expressed by the group.

The first loop

Planning

The initial group interview showed a group of nurses who were fed up 'doing everything that no-one else wants to do' but were unsure of how they could make any changes. This they blamed on the 'system' which they described as:

> having been started as S.O.S. (Sisters Overseas Service) so that the social workers used to see people and counsel them and then a doctor would see them and then the social workers would get them out to the airport on a plane to Sydney, they'd pick them up from the airport, bring them back. There were no nurses, the social workers did everything. AF/G1.

This apparent dominance by the social workers has continued in the nine years that the clinic has held a licence to carry out abortions, with any review of the service to accommodate increasing workload simply being an increase in staffing, with social workers always outnumbering nurses and "only allowing us to go near the patients when they said so" (MC/G1).

The nurses, therefore, were frustrated at their perceived inability to make changes and were seeking help because:

> we're fed up doing the dirty work and why can't we do other things for the women such as teaching and being with her throughout her stay in theatre, rather than let the social workers do that while we get the stuff for the doctors? JK/G1.

The nurses' frustration appeared to be directed at the social

workers whom they saw as being 'all powerful' and not acting in the best interests of the women. Their main frustrations were not on behalf of their clients however, but were rather stemming from a lack of job satisfaction. This was summed up by one nurse who asked:

> Why can't we do the contraception? Why can't we do the group intake? Why can't we do the patient history? MP/G1.

Changes that were envisioned possible, by the majority of nurses, were therfore seen as a reallocation of duties, or a modification of the existing programme.

The nurse-manager, however, appeared to want a more drastic 'overhaul' of the clinic's internal structure and programme stating that:

> any change must be totally radical and implemented with a determination that would eliminate any possibility of weakness in the system. It must recognise the numerous diverse and specialised skills and abilities of the nursing staff. AF/G1.

The remainder of the nurses agreed that this 'would be a good idea' because 'the boss' knew best. While appearing to be supportive of each other, it is that type of remark that has served to retain the status quo, until now.

The concept of advocacy, which had been the original aim of the group was not raised until well into this first meeting, after the idea of 'radical change' had been discussed. As with the "boss's" plans for change, the group had appeared to think that advocacy was a good idea, but it was something

that would come naturally if only they 'were allowed' to do more. All had read the "Report of the Inquiry into the treatment of cervical carcinoma at National Women's Hospital" (Cartwright, 1988) and agreed that nurses should be advocates for their clients, but felt that this could only be achieved:

> by taking the power away from the social workers who run the show totally. Nurses aren't seen as important and we need to be more organised so that we can become more powerful. MC/G1.

A tentative plan was then formulated to increase the 'visibility' of nurses. The group agreed to consider ways in which they could see this best being achieved, while always keeping in mind the goal of advocacy (as defined in chapter two, p40). In order to do this we agreed to discuss at our next meeting some of the things that had been causing frustration in daily practice. With some of these identified, some firmer plans for change could be made.

Action

Contrary to the tentative planning described above, however, a decision was made by the nurse-manager to implement 'primary nursing' in a bid to gain some recognition and job satisfaction for nurses. The ability to make such decisions appears to imply that the nurse-manager does have some power, while also assisting the staff nurses to achieve their personal goals in relation to teaching.

As primary nurses, the registered nurses were assigned to a

group of clients as primary care givers with responsibility for:

providing all relevant information, including that concerning client rights.

reviewing the menstrual, contraceptive, medical and social histories.

contraceptive counselling.

ongoing client education for health self-awareness.

explanation of laboratory results and ongoing referrals as required (e.g. Sexually Transmitted Diseases Clinic).

formulating a client care plan.

determining whether more indepth or ongoing professional counselling would be appropriate.

Nursing staff were to be rostered alternately between the assessment clinic and operating theatre to facilitate the continuity of care, as client appointments generally occurred over a two day period, the first being devoted to assessment and education while the operation was performed on the second day.

Observation

While, as an 'outsider' it was not possible for me to observe day to day changes to nursing practice, the first individual interviews, together with the diaries of some of the participants, revealed some of the thoughts of the nurses about their new way of practice. One of the longest serving staff members who may have been expected to resist change was most vocal in support of the change:

> after years of being the dogsbody for everyone else, it's great to be a practitioner in my own right, even though there's resistance from the social workers. I didn't expect to like it, but I was fed up with the old way, and this is just great. Jag/I1.

This was endorsed by two of the more recently recruited staff nurses one saying that "it was great for the patients and the nurses, when they got the chance to do it" (Pam/I1) and the other agreeing, but commenting that with little support from management in times of holidays or sickness "we don't have much hope" (Margaret/I1).

One nurse, however, did express some misgivings:

> I wonder if we haven't just replaced one set of health professionals with another. It seems that it's the women who should count and they don't appear to be getting any more choice in their care than they used to. Katie/I1.

The other concern expressed by all the nurses in some form was 'the attitude of the social workers' whom they felt were smarting at losing some of their power. This they believed

was because not every woman was being referred for counselling, that was a joint decision made by the client and primary nurse and the social workers were left with time on their hands.

Analysis

The major overt issues to arise from this preliminary loop of the research were those of power, and knowledge, while permeating every discussion was the concept of communication. These will now be individually analysed, according to the data obtained from the first individual and the second group interviews, together with exerpts from participants' diaries.

Power

Power was expressed by the group as the central issue in the need for change. It was summed up by one group member as "it was just so bad, we had no power to do anything" (JK/G2). All power appeared to rest with the social workers who:

> took charge of the whole procedure, meeting all the women at the door, dividing their notes into two piles one for them and one for the nurses. The nurses got to do the medical histories of the patients who weren't being counselled at the time. CE/G2.

Power, therefore, to the nurses, was tied to the ideology of domination (Faraganis, 1989). The nurses had been dominated by the social workers, ever since the opening of the clinic and primary nursing had given them a chance to gain some

power for themselves. It was felt that the social workers were more concerned with letting the clients know what services were offered, rather than empowering them in their decision making. One nurse expressed it thus:

> The social worker's time with each woman seemed to be allocated on the basis of how many there were. For instance if we had a quiet day, each woman would have a correspondingly longer counselling session....the first person they saw was the 'floater' (coordinating social worker of the day) who sorted them out, then another one came and did a group session, then the individual counsellors came along and did their bit. Alice/I1.

The social workers by this prescriptive routine, thus adhered to the medical domination of the health service, and indeed as their recommendations often saved the doctors considerable time, their involvement with the clients was seen as invaluable to the medical profession.

The nurses felt that it was appropriate for their clients to participate in decision making. They did not see this as innovative, nor did they identify with the clients as women who, like themselevs, had been oppressed by past injustices within the health care system. This was contradictory to some of their earlier expressed feelings that as nurses they weren't 'allowed' to do anything.

Nurses, therefore, saw 'the system' as oppressive to them but saw the client as outside of this system, so capable of making decisions which were personal to them but not disruptive of the clinic's schedules. The clients were thus

perceived as more powerful than the nurses in terms of individual decision making, but the nurses felt that neither they nor their clients had the power to change the system.

Some nurses however, felt that this was rather unfair as "really the doctors weren't around very much, and they've been very supportive of primary nursing" (JK/G2). The advent of primary nursing probably made very little difference to the medical staff because their main roles at the clinic appeared to be ensuring the consent forms were signed and performing the operation. It therefore made very little difference to the attending physician as to who completed the preliminary paperwork, that was a minor detail as long as it was in order. The subtle power thus held by the medical profession maintaining their dominance (Lukes, 1974) was not recognised by either the nurses or social workers.

Knowledge Nurses at the clinic argued that they had the knowledge to participate in a much more active manner in client care, than previously. This knowledge was described as a set of skills:

> I saw a girl with a previous D.V.T. (Deep venous thrombosis) the other day, so I was able to advise her about why she shouldn't take the combined pill. MC/G2.
>
> We've been trained to do a lot of things, like the medical history, and most of us have been to family planning courses so we can teach the patients about contraception, we know how the operation process works, so we can teach them that... JK/G2.

Knowledge was therefore considered to be technical in nature (Habermas, 1972) and nursing practice described as a series of tasks. The nurses considered that they knew more than the patients and were 'just as capable' as the social workers, but they did not 'possess' as much knowledge as the doctors. By means of their greater knowledge, the doctors, therefore, had the right to maintain the positions of power which they held. The nurses did not consider however, that their knowledge may be 'different' from either of these groups and in that 'differentness' lies a potential source of their power. This supports the notion that it is because the relationship between power and knowledge has been unrecognised that power has been viewed as oppressive (Foucault, 1975).

The nurses considered that the difference between themselves and the social workers was that the social workers could undertake professional counselling while the nurses could not. Counselling, to most of these nurses appeared to be the social workers' territory and not within the "scope of our job descriptions" (CE/G2). There was considerable dissent here, however, some nurses feeling that the giving of information was a form of counselling while others said that this was 'merely advising.'

In general, however, the nurses felt that in the primary nursing setting:

> it is our job to recognise which women need counselling and refer them to the social workers for this. We have only got the skills to advise and teach. MP/G2.

Counselling thus appeared to be something almost intangible and eluding description but which required specialist skills, out of reach of most of these nurses. Nursing knowledge did not encompass this art, but rather was constantly described as various skills which were acquired during 'training' and which could be put together and used to "do everything that the women need when they come for their abortions" (MP/G2). For these nurses to be able to counsel would mean attending a specialist course which would teach them the further skills to add to their repertoire.

Communication

Early in the first group interviews the nurses expressed unanimously that to be effective client advocates involved them in conveying information on the client's behalf to medical and other staff as well as assisting them in decision making processes. This they believed would evolve naturally from the process of nursing assessments and care planning on an individual basis. However, it was also expressed that:

> by individualising care it also gives the woman a chance to make some decisions and enable the doctors to function more efficiently. MP/G2.

Here the nurses also appeared to be expressing some of the dilemmas previously found by nurse-authors in their attempts

to define an advocacy role for nurses (Jenny, 1979; Porter, 1988). The nurses here, while expressing the desire to act on behalf of their clients were, in fact unable to relinquish their traditional role of 'doctor's handmaiden'. While concerned with their clients, therefore, their primary loyalty to the smooth running of the system may have acted against these clients.

Pre-existing patterns of thought, which had been defined for this group, first by their nursing education, and reinforced by organisational structures were not fully acknowledged at this point, hence such contradictions in their expectations. Further contradictions were also seen in relation to beliefs about the nature of nursing knowledge as outlined above and the institutional values and practices therein. Because of such pre-existing patterns, the move that these nurses had made to primary nursing had created a sense of satisfaction for them in that they were now the ones with some power, while the social workers were thwarted.

It seemed at this point having completed one loop of the action research method, that it was destined to rest here, with no chance of further investigation. The nurses were now happy with their role, they saw themselves as now being 'superior' to the social workers and were contented, even though no structural changes had taken place, and there appeared to be no shift in the dominance of the medical

profession or the dependant nature of the clients. There certainly appeared to be no progress towards the advocacy model outlined in chapter two, but rather it seemed that the nurse had taken over the role of 'counsellor' as decribed in chapter two, p32) by Abrams (1978) and which had previously been fulfilled competently by the social workers.

Carr & Kemmis (1983) warn against single loops of action research, doubting that this should be considered as action research at all. The ethics of 'interfering' where it appeared unwarranted, however, prevented my further intervention at this point, although I knew that only superficial issues had been raised. This had not yet been recognised by the participants.

The second loop

Planning

It was to be only two weeks later when I was asked by the group to return because some 'unexpected difficulties' had arisen. These, they believed threatened the existence of primary nursing, without which, they stated they could not possibly act as advocates for their clients. The discussions which resulted from this call indicated that 'management' was concerned that as there appeared to be insufficient nurses to carry out primary nursing, the social workers should be better utilised. With this in mind a review of the service was to be carried out.

Concern at the loss of their newly gained 'autonomy', served as the trigger in starting to uncover some of the historic structures which have kept nursing in a position subservient to the medical and social work professions, in this particular clinic. As some of the nurses put it:

> it seems to me that the social workers in this abortion clinic are horribly well organised....and it really worries me, this gross manipulation of power, and they have used the patient and that bothers me. It seems that they are using the patient to manipulate the management into saying that the nurses can't cope.
> Catherine/I2.

> I think primary nursing's great, even if you do go home tired, you'd done a good day's work, helped people, followed people through, but because they won't find us the two nurses we're short, we're struggling, while the social workers are planning their next move. Pam/I2.

> We've been two nurses short, of even our ridiculously low ceiling for ages now, but they (management) seem to be hanging back and not advertising. It's as if they're setting us up to fail. Alice/I2.

The nurses were therefore feeling a lack of support from management and total resistance from the social workers. They also began to realise that it was the clients that were caught in the middle:

> I've had a women this morning who's been using homebake .... I felt that she felt really confident in me and when she came in this morning I said 'please tell me if you've had anything this morning' so she did and then she asked for some information about the methadone programme. I suggested we get a counsellor to talk to her about it but she hates social workers, so I went to get a leaflet and the social worker wouldn't let me get it unless the woman went to see her. Jag/I2.

The nurses realised that they had to convince the management

that they were able to be the primary caregivers for the women attending the clinic, having the skills to make nursing assessments and refer to other health professionals as needed:

> I see the unique role of the nurse is to coordinate all the care of the women, not just the physical care, but emotionally as well...I mean you use doctors as professionals and dietitians for example, so why can't we use social workers in that way and make referrals to them as required? Catherine/I2.

However, the group were also beginning to realise that the drastic change that they had made, while providing job satisfaction for them, had created much dissent amongst the social workers. Advocacy remained their ultimate goal, and primary nursing a stepping stone towards that, but acting in isolation from other professionals, had actually worsened the situation.

Planning for the future, therefore, meant looking at nursing practice in relation to the overall services available at the clinic. Some concerns were, however, evident:

> Anything we've tried to do before, they've (the social workers) rubbished and because they outnumber us by three, we can never get anything done if we tell them. It seems that we're destined to remain the dogsbodies if we consult. AF/G3.

> One of the counsellors said yesterday that she doesn't like to see nurses without their uniforms and badges on and things like that ...and she said that 'nurses should be standing by for when patients needed them, and for teaching hygiene, that's what they're there to do.' LC/G3.

The main concern of the social workers, however, was that they considered that "not enough patients were being seen by them" (JK/G3). Nurses, however, felt that at last women were being given a choice as to whether they wanted counselling. The Contraception, Sterilisation and Abortion Act (1977) stipulated that counselling services must be available but as Nicol (1987) pointed out these need not be compulsory for all women and indeed many women chose friends and family to confide in before first approaching their general practitioner as the primary point of referral to the clinic.

The uncertainty of the nurses was thus evident with some expressing that if the social workers were all to leave:

> we could do the job just as well. I chose to work here because of my background in dealing with emotive issues. I mean I've been responsible for severely depressed people thinking of committing suicide, so my counselling skills must be fairly good to cope with things like that Catherine/I2.

while others had some reservations:

> I still feel that nurses aren't that good at picking up what a woman really feels. Some are and some aren't but social workers have had some training so they can pick up the little triggers that I might miss. Katie/I2.

With these contrary views being expressed, it was again difficult to engage in any concrete planning, rather the aim seemed to be to uncover some of the issues that previously had been hidden from the nurses, by their acceptance of the status quo and their own domination. However, the concept of primary nursing remained attractive to the group, as a stepping stone towards advocacy. It was decided to persist

with this, while recognising its accompanying responsibilities, the limitations of the social workers' model of counselling, and the resistance experienced from that group.

Action and Observation

There was little visible change to nursing practice, but as the group became more aware of outside conditions affecting client care, they were able to observe and focus on some of the constraints which still influenced their practice. Some of these observations were documented in diaries and others voiced in the second individual interviews. One practice which was frequently commented on was the social workers accompanying to theatre clients who had attended them for counselling:

> some patients I've observed in theatre who are accompanied by the social workers appear psyched up unnecessarily and I wonder if they would not be managed better by a doctor and a nurse who are well used to taking people through the procedure. Catherine/D.

> we're always happy to allow a support person into theatre, even if we havn't much room but it's a bit of an insult to the patient when she doesn't have any choice as to whom that is....more often than not it's the counsellors. Alice/D.

> as nurses we're trained to support people and I feel that it's our job in theatre to be that support, especially when the woman's not 'out' (anaesthetised) it's just treating us like dirt when 'they' (the social workers) walk in and waltz all over the place. Margaret/I2.

In regards to their own practice, observations were made as to how hard it was to 'do' primary nursing when the social

workers were breathing down their necks, waiting for them to make a mistake. One comment was made that:

> I have to be constantly on my guard because I never knew if I was being set up by a patient on behalf of the social workers. Catherine/I2.

while another commented:

> 'they' say they've got letters of complaint from some patients but they're confidential so we can't see them. We accept that there's always going to be a percentage of women who are going to be unhappy no matter what we do, just as there are some who will be happy as long as they get that abortion. Margaret/I2.

Analysis

As the nurses began to gain an awareness of some of the constraints on their practice, and the potential for a nurse/client relationship, the concepts of power, knowledge and communication began to take on new meaning. These will now be discussed, but like the moments of the action research spiral itself these cannot always be separated.

Power

Power remained a central issue throughout the period of this research. The nurses, although making a change to their practice felt powerless to achieve their goal of acting as advocates for the clients. This was reinforced by the doctor/manager of the service who totally rejected the idea of nursing advocacy. As one nurse explained:

> as nurses we were all acting as patient advocates by allowing them choices in their care, but he said we couldn't really do that as we didn't have the power to make available beds that the doctor says have to stay free or add to the list or bring somebody in. LC/G3.

Power, was therefore seen by this doctor/manager as a means of controlling both the nurses and the clients. Not only was medicine exerting its continuing control over nurses, but also over clients, by this restriction of 'numbers'. Such control was further manifest through the social workers who continued to use a medical framework in their approach to counselling, using this as an opportunity to 'advise' clients as to what would happen in the clinic, thereby ensuring a smooth operating session for the doctors.

Power used for the purposes of control in this manner was generally covert rather than being openly coercive. It did remain, however, the hidden agenda within this particular clinic and while nurses were beginning to recognise the power of the social workers as oppressive, did not connect it to the actions of the medical profession. This was despite comments such as:

> my concern today is paramount as social workers have now instituted a group discussion which the women have to attend. Here they give out all information about the operation procedure, so all that's left for the doctors is to get them to sign the consent form. Catherine/D.

Nurses, therefore, saw the social workers as taking away some of their work, rather than allowing the doctors to continue to avoid their responsibility for providing clients with a full explanation of surgical procedures in order that informed consent to the procedure may be given or withheld

(Cartwright, 1988). Thus medical staff continued to evade their responsibilities towards the clients, the gap being breached by the social workers.

While nurses saw themselves as relatively powerless beside both the social workers and the doctors they accepted the doctors' right to this power, but did not accept it as the right of the social workers, who were described as:

> a powerful group of women who were so organised that it was hard to outmaneouvre them at any stage especially while they were sitting around with little else to do while the nurses had been run off their feet. MC/G3.

The nurses were challenging the power of the social workers by instituting primary nursing, but this was still being achieved through reallocation of certain tasks, rather than reconceptualisation of the whole organisation. The emancipatory knowledge required to uncover the surrounding dominant structures had not been fully developed thereby the more sublte power of the medical profession remained supreme.

Hegemony

Hegemony has been described in chapter three (p.51) as providing the approach where, by means of coercive power and intellectual and moral leadership a dominant class has the ability to exercise social and political control. Relations of domination are maintained and reproduced through the actions of both dominant and oppressed groups.

The beliefs expressed by these nurses in the legitimacy of the power of the medical profession, were maintained throughout the period of this research. One nurse for example stated that the doctors were "very supportive" of primary nursing (Jag/I2). The nurses also recognised that with reorganisation so that not every woman had counselling it made certain disruptions to their "very busy schedule" (Alice/I2) but all were endeavouring to keep these disruptions to a minimum, in order to keep things running smoothly. This is despite certain recognitions such as:

> when the doctors are here they're supposed to stay for the whole session, (a period of four hours) especially if we've used hypnoval, but usually they're out the door as soon as the last one's finished. Easy money.
>
> Alice/I1.

There was no mention of questioning this procedure, the nurses in fact appeared envious of such freedoms. The clients, too, maintained this subservience to the doctors, several nurses saying that often conversations amongst clients centred around whether to address the consultant as 'Mr.' or 'Dr.'

While focusing on nurse/doctor relationships these remained centred on the present situation in this one clinic and not related to the development of health services for women elsewhere. The issues of nurses and clients as women, in contrast to doctors as predominantly men was not discussed. This is possibly because the social workers, another group of

women, were seen by the nurses to be powerful. That this latter group adhered to and promoted the medical domination of the health care system blurred the issues of gender inequality.

The concept of hegemonic masculinity as outlined in chapter three (p.53) was therefore not surfaced and so the ruling social order was maintained by this reification of the existing hierarchy. Structures promoted by medicine and supported by social workers were seen as natural by the nurses and clients, so were assumed to be fixed and unchallengeable. Alternative ways of viewing reality were not fully explored so limiting possibilities for choice and action.

Knowledge

While as previously stated, emancipatory knowledge had not been fully developed by the participants at end of the second loop, the nurses had advanced beyond talking of knowledge solely as skills they had 'acquired in their training'. Personal experience was coming to be seen as important one nurse claiming:

> we're all women, us nurses, sometime or another we've all had to decide if we want to have children or not. Surely this has some bearing on how we can advise these women? I think we've got to help them make up their minds then support them in their decision, rather than say 'if you want abortion you must come back at 9.30 tomorrow'. Katie/I2.

According to the nurses personal knowledge seemed less important to the social workers who still counselled according to the length of 'the list' despite the differing needs of different clients. Nurses were beginning to recognise that their knowledge was different from that of the social workers, and could be used to the clients' advantage. Acknowledgement of the individuality of each client by nurses for example, meant that some of the limited power held by the nurses was shared with the clients:

> we're here for the patient, to support her at the time and also afterwards if she realises that she's not coping and has no-one to turn to she must feel she can come back. CE/G3.

> patients are the reason we're here, I mean I spent a long time with a 15 year old girl this morning, just educating, talking and sorting out problems, so that she could make some decisions. All her life people had made her decisions for her. Jag/I2.

> we're here to help the women make choices. No-one else seems aware of that, though I suppose they have made a choice to come here in the first place, but when they get here they just seem to want to do whatever they're told. I don't think we should be telling them to do anything. Margaret/I2.

This recognition of the client as central to nursing practice represents a big step forward in the thinking of this group of nurses, who previously had been solely concerned with their own job satisfaction. The knowledge of the client is also seen as important in the relationship, which despite covert medical dominance, appears to be developing toward one of partnership between the nurse and the client. It is this recognition of the importance of women's experience which the

nurses see as unique in their relationship with the client and which has been unacknowledged by the social workers, who despite being entirely female, continue to practise within the male-dominated medical paradigm, in which knowledge is seen as technical. For example:

> all the patients were treated the same by the social workers, whether they were brown or white, young or old, apprehensive or confident or with friends or alone.
> AF/G3.

or:

> I think a lot of the women just go along with the system, because they think if they don't then they won't get an abortion, and it's important that they do get that abortion, after all that's why they're here.
> LC/G3.

but nurses:

> are quite capable of working with each woman to find out what she wants in the way of counselling. If she's talked it over with her family at length or has a supportive partner, then counselling may only put her back up. Alice/I2.

and:

> we need to provide and ensure that the woman calls the shots and not use our positon and authority to influence the decision or outcome of the decision. Katie/D.

Nurses, then were able to work with their own personal, subjective knowledge as well as that of the clients to change some previously accepted routines, but these were mainly on behalf of individuals.

Communication

As within the first research spiral, contradictions frequently occurred, not only with regard to the power of

other disciplines but also concerned with the practice arena of nursing itself. For example:

> most of our daily work is about advising, education, counselling, the patients are generally physically well, but emotionally in a turmoil, so if we can't counsel we shouldn't be here... not just here, but we shouldn't be registered nurses. AF/G3.

but:

> I don't think that we nurses should have anything to do with counselling, it's not what we're trained for. MP/G2.

and: We're so busy we haven't time to be doing in-depth counselling too, that's what they're (social workers) there for. JK/G3.

Statements such as these express the varying personal and professional beliefs of the participants. Personal beliefs as to the capabilities of the nurses became superimposed upon by institutional regimes and the values held therein. By practising according to the dominant ideology, the personal knowledge of the participants, derived from their own life experiences, was often denied expression.

Focusing on nursing practice as tasks which those involved may or may not be able to perform, acknowledges the importance of the smooth everyday running of the clinic to this particular group. However, such a focus tends to accept historic practices as natural, and fails to surface the true nature of many of the taken-for-granted practices of these nurses.

The dominant ideology, thus was able to systematically

distort the communication (Habermas, 1972) within this group of nurses. At times the group felt they had freely reached a rational consensus with statements such as:

> We (nurses) can organise the assessing clinic and talk to the women and, more importantly listen to them so that we've all got some idea of how we can work together and what else is needed. AF/G3.

but further discussion revealed that this could only be so if:

> it doesn't disrupt the doctors' schedules. They don't like seeing the women in their street clothes as it is, it means that too much time is lost. MP/G3.

The discussion in which these statements were made reflected the inability of the group to penetrate beyond individual, often isolated events concerning the day to day activities of the clinic. The inability to acknowledge all of the pre-existing patterns of thought means that the dominant beliefs of the group could not be validated when subjected to rational discourse within an ideal speech situation (Habermas, 1972). In such a situation agreement by superior reasoning, rather than coercion, could not be reached because of numerous contradictions such as that outlined above.

Conclusion

To move beyond the constraints and frustrations described above requires a certain level of critical reflectivity. Two loops of the action research spiral were completed, during which initially this was only momentarily experienced. However, later some of the nurses were able to surface the ideologial nature of their practice worlds. More often,

however, it seemed easier to challenge the practice world of another group of health professionals, that of the social workers, rather than surfacing the oppressive nature of their own work.

In working towards the goal of advocacy, however, a little progress was made, as the nurses began to share their personal knowledge with the clients, and acknowledge the subjectivity and womanhood of these clients. By working together, a basis for further loops of the research spiral would be made possible in the future, and perhaps this group's goals achieved.

This study has moved beyond an attempt to define advocacy, in this particular context, but has explored a process involved in becoming advocates. It has recognised that to become an advocate, the social conditions of the practice world must be taken into account and in particular the constraints on action identified with the aim of their removal. The final chapter considers the findings of this study in relation to nursing education, practice and research in the future.

CHAPTER SIX

Discussion, Recommendations and Limitations.

This research has presented the data for a critique of the way in which registered nurses experience power within the structures surrounding their practice. The research process has provided a useful framework for the analysis of these power relationships as a means of demonstrating how these constrain the personal and professional values of these nurses, preventing them from assuming the advocacy role outlined in chapter two. In addition, some of the contributing factors continuing to influence the power structures within the particular practice world of these nurses have been identified and discussed.

While it has been emphasised that the participants in this study were not a sample representative of a larger population, this study, nevertheless does have implications for the wider areas of nursing practice, education and research. In this concluding chapter, the implications of this study in relation to these area are discussed and recommendations made. Limitations of the study are also identified and discussed.

Implications for nursing practice

As discussed in chapter four (p69), emancipatory research is grounded in the ability of the participants to engage in a process of reflection and self-transformation. In order to

achieve this self-transformation participants must move beyond the technical knowledge so commonly found in nursing practice and instead, aim at discovering emancipatory knowledge as a means of recognising the root of the power structures constraining their actions.

In this study some of the ways in which the power of the medical profession, reflected in institutional, taken-for-granted practices have been identified. This power has worked negatively to constrain, rather than facilitate, the development of the emancipatory knowledge necessary for enlightenment and emancipatory action of the nurses who participated in the study. As Stenhouse (1982) says it is studies such as this which open institutional processes to scrutiny, thereby shifting the balance of power.

Within the clinical area, contradictions between what the nurses believed they should be doing on behalf of their clients and what the organisational structures permitted were evident. For instance, the nurses expressed a belief that their clients should be fully informed about possible implications of abortion so that they might make decisions based on this information, but the length of time that the institution allocated to the nurses to spend with the clients did not permit this free exchange of information to take place. Thus the professional ideals expressed by the nurses were 'kept in their place' by institutional practices.

Such institutionalised domination often provides the conditions in which emancipatory interests develop (Hickson, 1988). However, in this institution, so strong was the dominant ideology that these interests only began to surface after several meetings. The participants were thus only beginning to recognise some of the forces and counter forces influencing their practice.

According to Street (1989:63) this is typical of hospitals which:

> maintain their existence by a series of mechanisms which are productive and reproductive in function but which serve to mask the power relations at work.

Thus, power relations are often seen from a point of view which reflects that institutional framework. The nurse/social worker scenario is one example of the power of the institution disguising to the participants the true nature of this power. To expose this and move beyond it would require considerably more self-reflection of the group in order to bring to consciousness that which has previously been unconscious. Such self-reflection would bring to the fore the new understandings of previously taken-for-granted assumptions in order that alternative possibilities for action may be realised.

This is a position that has been greatly challenged by

feminists who argue that in all women's groups, for example, mechanisms for discourse which are nurturant and non-verbal are often developed (Spender, 1981). The participants in this study often appeared to 'nurture' other health professionals. While expressing a collective dislike of social workers, they admired them for being 'organised' and at all times they were supportive of the medical staff. The apparent contradictions that they experienced were thus seen as unrelated, or were accounted for by means of personal explanations. They were therefore seen as being part of the 'natural' hierarchial nature of the public health care system of this country, which 'naturally' has its imperfections.

Despite being frustrated with the scope of their practice, therefore, this group of nurses tended to see the 'system' as independent of themselves, something that they could help to cure if the cure was initiated by someone with more 'power' than them. Established institutional power structures, therefore, denied these nurses the opportunity of enlightenment and through enlightenment, emancipation.

This study has shown that the way nurses understand and interpret their practice world is dependent on the particular socio-political context of that practice setting. While the shared understandings of the group were found to be "ideologically frozen" (Comstock, 1982:384) thus preventing the full development of new possibilities for enlightenment

and action it is possible that reflection will continue within the group allowing understandings to be reshaped and reformulated.

The opportunities for coming together and engaging in such dialogue may provide other nurses with the means for engaging in radical analysis and critique of their own practice worlds, with a view to altering some of the conditions which they find most constraining. This is particularly essential in these times of changes in the health service, if nurses are to contribute to this restructuring in ways to positively promote nursing practice. It is only by this coming together that nurses will realise that they are not acting in isolation, but rather allow shared understandings to surface and be explored.

By sharing of experiences and understandings, nurses are more likely to view power as a positive tool with which they can change their world. In this way power becomes inseparable from emancipatory knowledge as together the two expose the constraints on nursing practice. It is this drawing together of emancipatory knowledge and power, rather than quality assurance audits based on technical knowledge, which will truly provide the means by which nurses can be a powerful force in restructured health services.

Such a restructured health service would move away from the

patriarchal ideas and institutions created by medicine toward what Ashley (1972:77) describes as a "woman defined, woman created world." It is only in a world such as this that nurses would be able to fully assume the role of advocate which they desire, as until all the hidden constraints have been surfaced, a full range of choices cannot be offered.

It is not only the structures in which nursing is practised which must alter drastically if the types of constraint identified in this study are to be overcome. Nursing education must also be prepared to alter to meet the new needs of the nurses engaged in clinical practice.

Implications for nursing education

Most nursing educational curricula are still based on Tyler's (1949) objectives model. This is derived from behavioural psychology in which technical knowledge is dominant. The emphasis on attainment of skills rather than the personal growth of the learner (and the teacher), has led to the artificial separation of knowledge from understanding and theory from practice.

This separation of those who conceptualise knowledge from those who execute it is maintaining the effect of others controlling nursing practice. The central feature of this approach to education is 'control' with the structure of knowledge being intimately related to the principles of

social and cultural power and control in a society (Bernstein, 1975). This has been reinforced by Freire & Shor (1987) who describe this approach to learning as the 'transfer of knowledge' approach and suggest that it is constructed primarily to maintain the dominant ideologies of society, which sustain elite authority.

In this model, theory is seen as a basis for practice rather than being an integral part of practice. Education of nurses is therefore seen as isolated from the practice of nursing thereby 'decontextualising' nursing knowledge. Nursing, therefore, despite the potential for change, which was offered with the transfer in basic education from hospital schools of nursing to tertiary institutions, has submitted to these controls and offers no threat to the powerful echelons of the health care system. By nurses transferring their knowledge to student nurses, who in turn transfer their knowledge to clients, the hierarchial order is strictly maintained, with clients at the bottom of the ladder and nurses one rung up. There is no challenge to the status quo and the powerful minority remain firmly ensconced.

Educational institutions, therefore, need to acknowledge the 'hidden curriculum' which encourages the socialisation of nursing students into acceptance of taken-for-granted structures in the health service. Instead of being encouraged to be self-critical, students of nursing should be

initiated into self-reflection within the social and political arenas of the nursing domain, thereby creating the basis for a challenge to dominant groups which shape nursing practice.

Educational and practice institutions, therefore, need to be supportive of one another, providing opportunities for nurses from both settings to share experiences, with a view to developing critical reflection of these experiences. In this way students and graduates in clinical settings will come to question some of the taken-for-granted practices and explanations, and participate in their reshaping and reformulation.

Institutions which encourage reflective thinking and practice, would encourage diversity and change, therefore such reflection should not be construed as a destructive attack on existing structures. Instead, by this working together, nurses can ensure that the organisational climate becomes conducive to and supportive of the legitimacy of nursing practice based upon nursing knowledge, dependent on the development of emancipatory knowledge.

Given such a supportive climate, nurses would be able to engage in socially critical self-reflection, and so begin to take seriously professional rights and responsibilities in the changing health care system.

Such educational practices are just as relevant to client education by nurses within the health care system. Clients and nurses, therefore, must work together to critically analyse their experiences with a view to reconceptualising the balance of power in client education in the future. This kind of relationship is more likely to achieve active critical dialogue, which may result in the client gaining awareness of herself as a subject rather than an object capable of being manipulated by the 'authorities'.

Education in this framework should gradually empower clients to be creative rather than accepting, with the nurse-teacher providing the supportive environment for this process to develop. In this way effective and satisfying nursing practice dependent on emancipatory knowledge and a reinterpretation of power structures may result.

Limitations of this study

While this study has begun to identify some of the ways in which institutional practices and dominant ideologies have led to the oppression of nursing, it does have some limitations, particularly in regard to the primary aim of the study.

The major limitations of this work are the artificial temporal boundaries. The nurses who participated in this study began with a strong desire to act as client advocates.

However, throughout the period of the study, although this goal was reiterated on several occasions, the full implications of this role had not been realised by the group. Only limited progress towards this role had therefore been made.

As discussed in chapter four (p.84), it is acknowledged that the reflexive process is ongoing. There is therefore, no terminus which may be reached with all goals achieved. This would be in direct apposition to the methodology adopted and utilised for this study, and may be seen as both a strength and limitation of such an approach.

While the self-reflective process should continue beyond the time it has taken to complete this work, the written material can only record a small part of this process. However, in the initiating of this process, the potential for its continuation exists, not only in the practice world of the nurses involved, but also in that of other nurses who may read this thesis.

Artificial imposition of time limits has also meant that it would be impossible to predict if any change would occur, and if so when this would happen. Despite the initial approaches being made by the group who wanted a change, it was not possible to say if the changes that did occur were as a result of the reflexive process or if they occurred

independently of this. This means that Fay's (1987) fourth condition, that of transformative action (chapter three, p.56) for a theory to be considered 'critical' may not have been met. In the final group session, however, the participants did indicate that being involved in this study had helped them to see things 'that had been going on all along' (JK/G4) and which they hadn't realised were anything to do with their role in the clinic.

A further limitation of this study may be seen as the number of participants and the sole data collection method. The seven nurses working together in one setting, was, however, a deliberate choice as it was this group who wanted to work towards a change. The group was never seen as a sample generalisable to a larger population. Rather, this group, with its unique characteristics and patterns of interaction provided material for interpretation and critique on the basis of its members' experiences.

It is suggested that while there are some aspects of these nurses' practice that may be applied to other settings, that no other group of nurses will experience their practice in precisely the same way. It is up to the reader to reflect on the interpretation of these nurses' experiences to illuminate aspects of their own practice and so give them a 'surrogate experience' (chapter four, p.83).

As suggested in chapter four (p.83) the concept of triangulation needs to move beyond the idea of multiple methods for verification purposes. Instead, while the method of this study may have been seen as limited to unstructured interviews, data from group interviews was verified in individual interviews and also in the journals of participants. As the context of this study was the nursing practice of the particular group it was considered inappropriate to examine the main concepts independently of this group.

A further criticism of this type of work is that the concepts identified are not necessarily the only possible conclusions to be drawn. However, again it must be emphasised that this study was carried out from the point of view of the nurses involved. The constraints and frustrations experienced by these nurses were interpreted from a nursing point of view with regard to some of the surrounding structures. A management review of the same institution, for example, may provide totally different recommendations, resulting from application of different theoretical frameworks.

Finally, the material in this study may appear to be seen as emphasising the negative rather than the positive aspects of nursing practice. However, as Lather (1986) says, the catalytic validity of the study is met by the research reorienting the participants towards more positive outcomes

by means of rethinking their position before taking planned positive action (engaging in praxis). While only limited evidence of this was seen, due to the time constraints, this process may still be happening in the clinic.

Implications for nursing research

In the domain of nursing practice numerous problems, economic, political and social are being raised. It is through critical thought and research based on emancipatory methods that changes may be achieved. Thus the expanded view of critical theory, to include feminist perspectives (as described in chapter three) holds great potential in the development of research based nursing practice.

Studies such as the present one, therefore, have the potential to illuminate the social, political and economic constraints on nursing actions and are directed towards the emancipation of nurses from these unnecessary and unjust constraints. Such research is needed in both the development of therapeutic procedures and also at a broader level of analysis.

Nursing research based on the lived experiences of individual nurses such as undertaken by Benner (1984) and Patterson (1988) are also important, as this identifies the knowledge domains encompassed in nursing practice (Hickson, 1988). However, these domains, should also be considered in relation

to the historico-socio-political structures in which nursing practice occurs. It is studies such as this which have emancipatory intent which provide the basis for consciousness raising and transformative action. There is therefore considerable potential for studies with emancipatory intent to be carried out in the world of nursing practice.

Such studies might include the way in which gender has contributed to the development of existing social relationships within the health services. While this was touched on in this study, it needs further exploration, particularly as New Zealand has been described as a 'gendered' society (James & Saville-Smith, 1989).

Nurses might also consider jointly their relationship with other health professionals. While this study reflected nurses' views of their relationship with doctors and social workers, it was undertaken solely from a nursing perspective. Studies which included a broader focus, for example, working with an entire population of a specific clinical area, would also be of value to nurses and would reveal constraints of other groups of professionals.

Other possible areas for study of direct relevance, also include working with client groups. This has been carried out to a limited extent (e.g. Webb, 1985), but needs more in depth exploration, in relation to the New Zealand Health

Service. While of direct benefit to clients, such research also has the potential to greatly influence everyone concerned with the provision of health care.

There is thus considerable potential for research using emancipatory methodologies to be carried out, both in New Zealand and throughout the health services of the western world. These are vital in developing a critical consciousness so that past injustices may be exposed and praxis achieved.

Concluding statement

Through the use of a socially-critical approach, enhanced by feminist theories this study has demonstrated the ways in which the existing power structures of the health service constrain nursing actions and professional practice. The analysis of issues with emphasis on historical context and the aim of leading to emancipation from these structures is axiomatic to this study. The critical reflection on the ideological understandings which perpetuate existing structures is the means of activity for the purposes of transformation. This study has shown that to achieve an advocacy role, nurses need to first develop an awareness of the power and control which constrain their actions as autonomous practitioners. Nurses need to recognise that

while their practice is intrinsically bonded to that of other health professionals, they must clearly be able to define their own areas of expertise, within the historico-socio-political context of the health service. By developing such an awareness, nurses may then be able to transform some of the structures which presently they find so limiting.

APPENDIX

Information Sheet for Nursing Staff

My name is Valerie Fleming and I am currently working towards a Master of Arts degree, majoring in Nursing studies, at Massey University, Palmerston North.

I am interested in working with you over the next three to four months with an aim of jointly exploring some of the structures which have restricted your practice as nurses, and so effect positive change. In order to achieve this, data will be collected by means of unstructured, but focused interviews with individual nurses and the entire nursing staff in a group setting.

I will be approaching each of you personally to seek your permission to undertake this study, and give you a full explanation of the commitment required, and the implications of the study. I shall not be collecting any information which may be attributed to specific patients.

I also wish to point out that I am not interested in evaluating performance, and any information you choose to give me will remain confidential, and therefore will not be for use by hospital management.

Should you have any further questions at this point, I will be very happy to answer these. My contact address is:

P.O. Box 58,

Turangi.

Ph. 074-67306.

Thankyou for your time in reading this.

Consent to participate in Research Project

I have had the nature and purpose of this study fully explained to me by the researcher. I have had the opportunity to discuss its implications to my satisfaction. I understand that the research should result in changes to my nursing practice. My permission to participate in this study is given voluntarily, and I understand that I may withdraw this permission at any time, without consequences to my nursing practice or employment.

Signed Date

Witness

I agree to the use of a tape recorder to record interviews. I understand that I may stop the recording at any time, and the tapes will be for the exclusive use of the researcher and her supervisor. Tapes will be returned to me on completion of the research.

Signed Date

Witness

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