"They Can't See What we See"

Voices and Standpoint of Twelve Plunket Nurses

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ABSTRACT

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

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

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

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

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INTRODUCTION

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

REASONS FOR CHOICE OF TOPIC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THEMES EXPLORED WITHIN THE LONG INTERVIEW

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

THE APPROACH THAT WAS EMPLOYED AND WHY

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

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

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

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

THE STRUCTURE OF THIS THESIS

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

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

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

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

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

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

Part One: The Social Context and Method

CHAPTER 1

THE SOCIAL CONTEXT OF PLUNKET NURSES

The focus of this study—the reality of Plunket nurses—is extremely broad and the scope of the questions in the audio-recorded interviews reflects this breadth. Time and word constraints prohibit extensive literature reviews on all of the topics covered. Further than that, my intention is to record aspects of the views of Plunket nurses and then to begin to develop theory from the data gathered, rather than to begin with existing theory (see Chapter 2). I chose this topic because I had a strong interest in services centred on health as opposed to those centred on sickness, I was curious about changes that were occurring within Plunket nursing, and I had not found the standpoint of Plunket nurses reflected in the academic literature.

It is appropriate, however, to situate the realities experienced by Plunket nurses within their social and political contexts in order to add further dimensions of understanding and to provide a basis for the indication of change. The social context set out in this chapter covers the New Zealand health system, The Royal New Zealand Plunket Society, the discipline of nursing and the nature of relationship, and will necessarily be from my particular standpoint. 'Dominant narrative' and 'health' are key concepts within this standpoint, and require some clarification.

TWO CONCEPTS: 'DOMINANT NARRATIVE' AND 'HEALTH'

In the introduction to this thesis, I stressed the point that different people have different ways of seeing the world, and I noted that one standpoint often dominates all others. 'Hegemony' and 'ideology' are words that have been used to refer to this phenomenon of domination. Beatson (1990:259) argues that "the ideology of a dominant group in society can be thought of as a 'master narrative.'" I prefer the term 'dominant narrative' because it is both self-explanatory and gender neutral. Although the dominant (dominating) narrative is the dominant view of the world, we are typically unaware of it. We have internalised it; it is natural, right and not to be questioned; and it becomes the reference by which we make our judgements. For example, the outcry against the suggestion that words inclusive of women as well as of men be used as generic words indicates just how 'right' the dominant narrative is perceived to be. Furthermore, the customary use of male gender words as generic

words illustrates the mastering aspect of language. By hiding the presence of women, this custom also legitimises the discounting of our voices.

In this chapter I present the idea that the medical profession has had the power to write the dominant narrative for health. The medical view has been the accepted view for most of this century, but this is changing. As different disciplines have developed within social science, as well as under the medical umbrella, conflicting views of 'health' have arisen, presenting challenges to the supremacy of the medical model. The result is an increasing difficulty in establishing a definition of 'health.'

Some disciplines focus on the health of an individual person; some on the health of groups of people; some on the mind; some on the body. Definitions are developed according to focus, and many are convoluted and difficult to understand. Wilson (1975:117) sees 'health' as a concept which like 'truth' is impossible to define: "To define it is to kill it," he writes. This may be why many health professionals, Boddy (1985:17) for example, turn to literature for help and end up by quoting Katherine Mansfield (1977:278):

> By health I mean the power to live a full, adult, living, breathing life in close contact with what I love - the earth and the wonders thereof - the sea - the sun ... I want to enter into it, to be part of it, to live in it, to learn from it ... I want, by understanding myself, to understand others. I want to be all that I am capable of becoming.

Pender's (1987:33) typology of health criteria offers a guide to how health is seen within different disciplines. The two disciplines within this typology most relevant to this thesis are those of medicine and nursing:

> **Medicine**—"health [is seen] as a physiologic process or state (biologic orientation)"—"[health equals] absence of disease."

> **Nursing**—"health [is seen] as a holistic process (biopsychosocial orientation)"—"[health equals] actualisation of human potential through integrated functioning of individuals and groups in interaction with their environment."

These criteria help to inform and clarify both the following discussion and the nurses' responses in following chapters. These criteria are also consistent with the view of health represented in the quote from Mansfield and with my own perspective. My perspective has been further informed by theories about different levels of prevention (see Shamansky and Pesznecker 1980), the health field concept (Lalonde 1974:31-34) and primary health care (WHO 1978). It underpins and shapes this thesis.

THE FORMAT OF THIS CHAPTER

The New Zealand health system, The Royal New Zealand Plunket Society, and the nursing profession, appear as dominant structures within the social context of Plunket nurses. In all three the medical profession has been ascendant. The chapter begins with an analysis of the literature on the New Zealand health system, because this is the context of nursing, as well as the context within which the Plunket Society developed and operates. Because of the over-riding influence exerted by the medical profession on the development of health services (including The Royal New Zealand Plunket Society, founded by a doctor) and public expectations of those services, the section on the New Zealand health system includes a particular emphasis on the place of doctors within it.

An examination of the Plunket Society follows logically from the discussion on different aspects of the New Zealand health system. Responses in this study suggest that the founding philosophy of the Plunket Society, together with prior Plunket nurse practice, has influenced current public attitudes towards, and expectations of, the Plunket nursing service. Beasley's (1993) thesis illustrates this point, and Norton (1990:162) reported:

> While the mothers said they wanted to know what the babies weighed, they often commented negatively that weighing was a central focus for the Plunket nurses. However the Plunket nurses said that they were inhibited from moving away from a focus on weighing because the mothers placed a lot of importance on this.

A closer look at the history of the Plunket Society will further facilitate understanding of the reality of Plunket nursing. This section will include a brief history plus a description of the structure of the Plunket Society at the time of interviewing, and a review of research on Plunket services most relevant to this thesis; namely, that research which reflects on the relationship between Plunket nurses and those using Plunket services.

Nurses receive their initial socialisation into their professional role within the discipline of nursing, which accordingly exerts a powerful influence over them. Therefore, I trace the development of nursing, beginning with the first Nightingale schools in the nineteenth century. Because the changes apparent in the interviews parallel the changes that are occurring in nursing generally, this history is of particular importance to this thesis. These changes centre equally on nursing becoming more independent of the medical profession and on the relationship between nurse and service user becoming more egalitarian. Relationship has emerged as a central theme within this study. Consequently, in order to add depth I will end with a discussion on relationship.

THE NEW ZEALAND HEALTH SYSTEM

This discussion pertains to the health system that has been developed in New Zealand. My three main concerns are how this system is perceived, how it might be perceived and the nature of the relationship that Plunket has with it. I will begin with a consideration of the term 'dual health system' which has been applied to the New Zealand health system over the last fifty years, then I will offer an independent analysis of the current health system and finally I will look at the place of Plunket within this second framework.

Problems of Designation

As with definitions of health, there are problems of definition and language within conceptions of the New Zealand health system. Cohen (1985:115) writes of 'ideological constructions' which are "full of contradictions, anomalies and paradoxes." He states (Cohen 1985:115): "These internal impurities reveal a hidden agenda, a message which is not as simple as the surface tale." This last statement can be applied to the clarity of language used to define the 'New Zealand health system.'

Since the advent of the 1938 Social Security Act, the New Zealand health system has at times been referred to as a 'dual system.' This is the case in the document, known as *The White Paper* (Mc Guigan 1975:47-59), in which 'the dual system' is used to refer to the broad range of public and private health services that developed following 1938. Scott, Fougere and Marwick (1986:74-77) use the framework of public, private and voluntary sectors in their analysis of the New Zealand health system, and within this framework they narrow the application of the term, 'the dual system,' to hospital services. They question the merit of the word 'dual,' on the grounds that 'dual' implies two separate systems, when in reality private and public medical institutions are interrelated. All receive government subsidies, and if private hospital use increases, funding to the local public hospital decreases proportionately (Fougere 1984:83-84; Scott, Fougere and Marwick 1986:76; Fougere 1990:160).

Use of the word 'dual' also masks the fact that many medical specialists work in both public and private hospitals. Doctors have more control over their working conditions and are better paid in the private sector (Fougere 1990:160), and they act as "gatekeepers for the free sickness services" (Chick and Pybus 1988:130). If doctors shift their time to the private sector, public hospital services are undermined (Fougere 1990:160). Instead of calling it a "dual system," Scott, Fougere and Marwick (1986:76)

describe it as, ".... a single, imperfectly integrated, but highly interrelated hospital system."

Likewise, the words 'health system,' whether or not they are prefixed by the word 'dual,' are ambiguous. I have observed that these words are often applied to medical services only. Other health services appear to fade into oblivion. The percentage of funding going to health protection and health promotion services offers some support to this view (Aitken 1977:39). Scott, Fougere and Marwick (1986:58) comment: "Overall, the level of funding to all these sorts of activities from the health vote is small." Doctors and their discipline, medicine, have held a prominent position in New Zealand for most of this century.

The Place of Doctors

Brookes (1986:133) describes members of the medical profession as "the new moral leaders in an increasingly secular society," Madjar (1985:39) traces the connections between the medical model and the natural sciences, and Davis (1982:225) exploring the reasons for the prestige that doctors have acquired, points out, "historically modern medicine achieved major acclaim in a period when the biological sciences reigned supreme." He describes the continuing prestige of modern science, the urgent need of people to be healed, and the vested economic interests of the dispensers of therapy and medicines as awarding doctors authority and rank.

Doctors have developed a strong lobby that has been responsible for modifications to government health policy. Doctors moved towards forming medical associations as early as 1876 (Hay 1989:34). In 1896 the New Zealand branch of the British Medical Association was established. Hay (1989:36) describes this move, plus the development of a medical school, as steps towards increased status and collective power for doctors. He points out that this was part of an international trend. By the turn of the century the medical profession was emerging as a powerful element in New Zealand society and elsewhere. In the years that followed, drives towards socialisation of medicine clashed with the medical professions interest in "private production and consumption of care" (Hay 1989:45).

There was a period of social reform in the 1890s (Sinclair 1980:172-188), but social policy aimed at promoting social well-being peaked around the decades immediately following the 1938 Social Security Act. This Act anticipated, by forty years, the 1978 declaration on primary health care by the World Health Organisation. In this declaration primary health care was defined as affordable, accessible and acceptable to its recipients, and as addressing "the main health problems in the

community, providing promotive, preventive, curative and rehabilitative services accordingly" (WHO 1978:34). Primary health care was described as "the nucleus" of a country's social and economic development. Members of the first Labour Government had well thought out social policies in which health was central. According to one source (Public Service Association 1985:3):

> Between 1936-38 the government developed a comprehensive policy package which had at its heart a health care system built around a community based preventive health scheme. The package included measures relating to housing, income, improved physical working conditions and the environment, as well as free medical care. It favoured a salaried medical service, and opposed the retention of the doctors' fee for service system.

The 1938 Social Security Act emerged after decades of interaction between doctors and politicians. Intransigence on the part of the medical profession resulted in the implementation of only some of the benefits listed in the original policy (Hay 1989:84-86). Sutch (1969:246-248) discusses the effect of the medical lobby on the first Labour Government's health policy, and Hanson (1980:124), writing on the 1938 Social Security Act, states:

> . . . the Act in its final form was very much a victory for the medical profession and demonstrated the strength of its bargaining power. The issue of universality may have been won by the government, but its general aim of a free health service for all had been diluted by the refusal of most doctors to operate a capitation scheme, or necessarily accept the government's fee for service as full payment for their services.

The first Labour Government's social policy package was "totally at odds with the medical profession's curative and individualistic approach to medicine and the treatment of ill-health" (Public Service Association 1985:3). Hay (1989:185-186) sees the conflict between doctors and government as having ramifications in social activity outside of health, claiming that it unwittingly brought shape to state provision of services generally.

Before the advent of the Social Security Act, one doctor's (D.G. McMillan) proposals were adopted by the first Labour Government (McGuigan 1975:43), while a second doctor (J.P.S. Jamieson), as the British Medical Association's champion, proved successful in lobbying government to modify these proposals (Hay 1989:91). This successful lobbying gave rise to what was often seen as 'the dual health system,' and it diffused the strong emphasis on health in the original policy. Hay states that the medical profession was already a powerful force in New Zealand and that Jamieson was seen as a "formidable adversary" (Hay 1989:91). Interaction between government and the medical profession has continued to be marked by conflict (Shannon 1978:1).

Within health policy advisory groups, doctors have outnumbered people who represent other interests. For example, in 1976, the Board of Health had eleven

members, six of whom were doctors. At the same time, a committee set up to review services in order to advise the Minister of Health "on all matters pertaining to the health of the pregnant women and her child," was heavily weighted with doctors (Board of Health 1976:5). Medical interests were overwhelmingly represented with no-one present to represent pregnant women. All four members without medical qualifications were registered general nurses with added obstetric qualifications. All four had received their basic nursing education under the medical umbrella. The composition of the Board of Health in 1976 and the committee reviewing maternity services at that time, is representative of the dominant pattern. Shannon (1978:1) observes: "Although a wide variety of professions and people are involved in the health services the major inputs into health policy have come from the medical profession."

Doctors have dominated also at the service level within the health system. Within the Department of Health, the position of director general has been filled by a doctor, and a doctor has headed each district office as Medical Officer of Health. Chairpersons of hospital boards have tended to be doctors, and the most powerful position within a hospital has been that of medical superintendent with authority over all other personnel, medical and non-medical. There has though been somewhat of an imbalance between the overall influence of doctors employed in public health activities and doctors employed in curative activities. Those with a focus on sickness appeared to have a greater influence in obtaining funding in comparison with those whose focus was health (Scott, Fougere and Marwick 1986:58).

Recent Changes

With reference to more recent developments, Fougere (1990:152-153) writes of the growth of a vast "medical-industrial complex" with the medical profession presiding over its creation and expansion. Doctors are the linchpin between powerful private interests such as drug and insurance companies and the public who have come to be known as consumers. The adoption of the market philosophy as a basis for health services is captured in the following definition of health from an economist: ". . . a durable commodity to be purchased, an investment to be made." Grossman, writing about health and health services, continues: "The end goal is an economic balance between the money and time spent in health behaviours, health services, health supporting products, health-related services and the level of health achieved by an individual, family or society" (Grossman [1972:1-2], quoted by Pender 1987:20).

The National Government of 1990-1993 implemented policy based on a philosophy similar to that underlying Grossman's statements. Consequently, the health

system underwent a radical transformation based on the market values of competition and profit-making (Upton 1991:22). There appears to be a continuing trend towards privatisation of services with state hospitals, now named 'Crown Health Enterprises,' and funding coming from additional charges for services, as well as from taxes. Troughton (director of the Crown Health Enterprise Establishment Unit) is quoted (*The Dominion* 10 May 1993) as predicting, "Competent Crown Health Enterprises would thrive, while others would lose out to a burgeoning private sector." The restructuring that has occurred in the last few years has placed general managers in absolute authority in Crown Health Enterprises, and professional hierarchies are now headed by generic managers. This trend has lead to senior positions within regional health authorities and crown health enterprises being held overwhelmingly by people with business backgrounds.

Nevertheless, the effect of the power of the medical profession is still felt. It seems that doctors have been displaced at political and administrative levels, but their mental framework continues to dominate. The medical model continues to influence beliefs, attitudes and policies about health and health care. As Davis (1982:225) puts it:

> The dominant perspective in health care is that of scientific medicine. It is this orientation that dominates our thinking about health problems and governs the deployment of resources in the health area.

Fougere (1990:152) agrees:

> In the twentieth century, doctors have won the almost exclusive right to define the meaning of symptoms, the treatments appropriate to them and, more generally, the meaning of health and illness.

Pascall (1986:166) suggests that medicine's greatest success could be as ideology.

The Medical Model

The medical model follows the process of noting signs and symptoms of ill health, followed by diagnosis and treatment. The focus within the model is sickness not health, and only part of the body is seen as relevant. This can result in a person being reduced to their malfunctioning anatomy—"the appendicectomy." Many aspects of being are omitted: psychological; spiritual; social; as well as much of physical entity. Madjar (1985:40) sees psychology and psychiatry as arising from an attempt to respond to disorders that the physically based model of medicine had excluded. She suggests that the resulting split of diseases of the mind from diseases of the body, has its origins in the mind-body dualism within 'Western' philosophical thought. Nevertheless, whether the focus is mind or body, the person is fragmented and the professional often reserves

the rights of the expert. Our dominant narrative has doctors as the ultimate experts on 'health.' Discussing the dangers inherent in such a situation, Cohen (1985:174) quotes Edelman (1977:60):

> ... when the power of professionals over other people is at stake, the language employed implies that the professional has ways to ascertain who are dangerous, sick or inadequate; that he or she knows how to render them harmless, rehabilitate them or both; and that the procedures for diagnosis and treatment are too specialised for the lay public to understand or judge them.

Since it has sickness as its focus, it is ironic that the medical model has come to dominate our thinking about health. When we talk about the 'health' system we are often referring to the sickness system. When we use the word 'health,' we seem to wear blinkers, seeing only sickness, hospitals and doctors. Sickness and health have become confused within Pakeha thought.[1] Morbidity and mortality figures are often referred to as 'health' statistics (Chick and Pybus 1988:128). When the Pakeha establishment refers to Maori health in this way the irony is particularly intense, with the Maori view of health encompassing social relationships, spirituality, mind as well as body. In its comprehensiveness the Maori view is the antithesis of the medical model.

Here I have discussed the power that doctors have gained. Doctors, with a primary interest in sickness, have gained sufficient authority to write the dominant narrative about health. What is often described as 'the health system' is often only that part of it that is centred on sickness, but health activities include services which focus on promotion of well-being, prevention of ill health and care of the dying, as well as on cure. They include the care that is given at home, mainly by women, to family and friends, the services of voluntary agencies such as The Royal New Zealand Plunket Society, major health activities carried out by territorial local authorities, the school health syllabus and so on. The words 'dual health system' appear to refer to the medical system, but the health system has wider origins. Described as beginning in 1840 as a hybrid system (McGuigan 1975:15), our health system could still be described as a hybrid system. Fraser (1984:53) offers the following:

> The diverse public, private and voluntary resources that are committed to the continued operation of this health care system are enmeshed in a bewildering array of overlapping agencies and responsibilities of central government, local territorial authorities, hospital boards, private facilities and voluntary societies. The health care system which evolved in New Zealand over the last 140 years is the product of a number of complex processes which include administrative growth and control in central government, fluctuating initiatives and responses from local authorities and voluntary societies, and more or less sustained interventions by a diverse array of special interest groups. In essence, it is a patchwork of provisions which are the result of ad hoc, pragmatic responses to an ever changing mix of economic, political and ideological factors.

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[1] An example from the *Evening Standard* 26 June 1993: "The Disabled Persons Assembly is unhappy at having people with disabilities automatically labelled 'sick' by being funded through the health system."

Fraser's word 'patchwork' seems more appropriate than 'dual' as a qualifier of the New Zealand health system, but when I try to tease out the strands within the New Zealand health system 'tangle' is the word that comes to mind. 'Tangle' applies also to the complex processes, identified by Fraser, that have shaped this system. In order to reach some understanding of the place of Plunket nurses in this tangle, I have begun to unravel it by looking at the agent offering the service, the type of service offered and its source of funding.

The Hybrid System

In this section I will set out my views of what constitutes the health system. Categories are not listed in order of priority, but I have put work which has been discounted, devalued and overlooked at the top of the list in order to highlight it. I have clumped together loosely activities involved with prevention and I have put treatment activities at the end. This is excepting the first category. People at home do everything.

- Care and support of people at home, given by people at home. This care is given to healthy as well as sick and disabled people. It includes health protection, health promotion, treatment and rehabilitation services. It is work that is usually done by women and does not receive monetary payment.

- Health education given formally and informally by individuals and within agencies, eg: by grandmothers, parents, neighbours, school teachers, leaders of scout groups, people in health collectives and so on. Some of these people are paid (such as school teachers), most are not.

- The work of voluntary agencies that have emerged as a result of inadequacies in the system. These agencies are numerous and diverse, ranging from self-help groups and interest groups that form to meet a local need (eg., the Cot Death Society) to international groups (eg., Red Cross). Many of these agencies require some kind of public funding in order to survive, and most of the people who work within them are unpaid.

- Territorial local authority services involve both health protection and health promotion activities. The latter vary from locality to locality and include services such as school holiday programmes and support (eg., housing and funding) for voluntary groups. Health protection services include a variety of activities, for example: provision of potable water, safe waste disposal, maintenance of building

standards. Standards for health protection are set by central government. Funding comes from local taxes (rates) and subsidies from central government.

- Regional and district councils also carry some authority and responsibility for areas of health protection (eg., pest control, noise control, clean air, clean lakes and rivers). Health protection work of regional and district councils is governed by national legislation and is publicly funded.

- Surveillance of the health of people at their place of paid employment. Responsibility for this now lies with the Department of Labour. Funding is both private and public.[2]

- Crown health enterprises (CHEs) also offer health promotion and health protection services. The directive for these often comes from central government and they are largely publicly funded.

  As well as primary prevention, CHEs offer secondary and tertiary prevention services which are mostly publicly funded. These until recently, have not been required to be profit making.

- 'Private' hospital, laboratory , doctor and other biomedical services which are partly supported by public money and which are also profit making.

- Health services offered within ethnic groups other than Pakeha, most of which do not receive public money.

- Treatment which is alternative to the medical approach, and which does not receive government funding (eg. naturopathy; homoeopathy; iridology). These tend to be profit making and do not receive public money.

Many of the categories listed above are a complex tangle in themselves. Health protection services are a prime example of this. These services are mostly publicly funded but they are spread across a number of agencies and like everything else their place within the structure is changing. Recent changes in legislation have altered responsibilities: for example, formerly, Area Health Boards and the Department of Labour shared responsibility for surveillance and maintenance of the health of people

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[2] I have not named all the agencies delivering health protection services. The Public Health Commission is meeting to establish the future shape of health protection services, and it is anticipated that these will continue to be delivered by a number of different statutory bodies. On page 71 of *Focus on the Future: Service Plans 1992/93* (Manawatu-Wanganui Area Health Board) it is suggested that these services will be delivered by "Crown Health Enterprises, Local and/or regional government and government departments such as MAF, Department of Conservation and Department of Labour."

in paid employment. Now all of these services are the sole responsibility of the Department of Labour and Area Health Boards no longer exist.

There are other ways of placing the above activities into a framework: dual health system; formal/informal system; the health field concept; levels of prevention; primary care/secondary care; and private/public/voluntary have all been attempted. The system is so complex it defeats a simple, straightforward, uniform method of categorisation. The above could be described as a 'nurses-eye view.' It is, in particular, the view of a person who has worked as a mother and as a public health nurse. It is the sort of view that a Plunket nurse could have. I have concentrated on the composition of the current health system with some reference to agency, function and funding. By focusing on activities connected with health I have excluded process, and process, including the policies of politicians and administrators, is what shapes a social system.

Many social phenomena have a direct impact on health. At this time in New Zealand the most pressing health needs for many people are adequate food and housing, and secure employment. Furthermore, a free public transport system, by facilitating access to facilities and services, could be a major factor in enabling people on low incomes to improve their health. A free public transport system could also lead to a decrease in the use of the automobile and thus contribute to international efforts to improve the health of the living environment. Perhaps the most pressing health need in New Zealand at this time is resolution of conflict surrounding Te Tiriti o Waitangi and the creation of a just society.

Plunket within the Patchwork of Health Services

In the schema that I have set out, the work of The Royal New Zealand Plunket Society comes under the heading 'The Work of Voluntary Agencies.' Like most voluntary agencies, The Society was formed to fill a perceived void in the health services in New Zealand (Parry 1982:13). Also, since there is no substantial wealthy upper class to act as benefactor and laissez faire economic policies are causing cut-backs in state funding to voluntary agencies, Plunket (like other voluntary agencies) is experiencing an increasing struggle to find money to continue. Additionally, the geography of the country—long, narrow and mountainous—together with the spread of population creates problems in cost of delivery and access to services. The present situation has some parallels with that of the late 1800s. Of that time, Fraser (1984: 57) writes:

> By the time of the 1885 Hospitals and Charitable Aid Act . . . . the State had become, albeit reluctantly, an increasingly permanent and in many respects the dominant participant in the overall provisions of medical and health care . . . the

> scattered distribution and small size of settlements, which persisted through the initial decades of European colonisation, meant that local authorities were seldom able to provide effective care, especially for the poorer members of the community . . . . the fairly widely held expectation that philanthropy, as had occurred in England, would help to fill this gap remained largely unfulfilled due to the absence of a substantial and wealthy upper class.

Although I have focused on Plunket as a voluntary organisation, I have noted also that the health system can be analysed in a number of ways. Most of the activities of Plunket nurses would fall into the category of 'primary prevention' from the perspective of levels of prevention (Pender 1987:4). That is, these activities are 'preventive' as the word is commonly understood. Within medicine such activities would be seen in relation to the public health model rather than the medical model. Scott, Fougere and Marwick (1986:58), for example, place Plunket with other voluntary agencies working in the area of primary prevention, and receiving some government funding. Plunket nurses work with people as they live their everyday lives. Their focus is health not sickness, prevention not cure.

In recent years there have been notable trends within health practices. These trends include a stronger emphasis on prevention and a movement towards people having more say in the planning and implementation of health services with each person taking responsibility for her or his own health. They have been reflected in the World Health Organisation declaration on primary health care (WHO 1978) and the Ottawa Charter for Health Promotion (WHO 1986). The first of these was a clear step towards improving overall health status with people having more power in decision-making about the health services they were to receive. The second, also with an intent to improve health for all, had a forceful emphasis on individual responsibility. The moves towards empowerment and self-responsibility have been so pervasive throughout health disciplines, I cannot imagine that the nurses working for The Royal New Zealand Plunket Society have not been affected.

THE ROYAL NEW ZEALAND PLUNKET SOCIETY

What is now known as The Royal New Zealand Plunket Society was established towards the end of the first decade of the twentieth century. At this time, throughout the 'Western' world, there was widespread concern over high child mortality rates and declining birthrates. Eugenics was a major issue (Oliver 1988:23; Tennant 1989:123), and the feminist movement was trying to re-assert itself yet again (Spender 1982). In New Zealand, Truby King was one of a number of prominent citizens who voiced concerns about the role of women in ensuring survival of race and Empire. King, a

The statements made by King, similar to those of other prominent citizens of that time, show that these people saw themselves as belonging to a superior class, which apparently gave them the right to 'educate' those who they saw as inferior to themselves (Grundy and Weinstein 1974:49-54). Plunket began with a set of defined standards which nurses were expected to enforce upon mothers and thus on infants (Tennant 1989:123-124). Although King had a major concern for the welfare of children, his attitudes towards eugenics and women promised that the resulting service would be one of social control, pressuring women into maintaining rigid routines for their infants. Oliver (1988:23) writes:

> King's system for enforcing upon women a regimen revolving around infant nurture was propagated by the Plunket Society...with weighty official and social patronage. His disciples were influential in the Department of Health and the medical profession.

For many decades the Plunket Society could be seen as having a 'civilising' role with regard to mothers and the development of twentieth century New Zealand. According to Olssen (1981:11):

> The Society could not expand during the War, but in the 1920s nurses, branches, Plunket Rooms, Karitane Hospitals, Mothercraft Training Centres, and ante-natal clinics multiplied. By 1930 some 65 per cent of all non-Maori infants were under the control and care of the Society; by 1947 the figure had risen to 85 per cent.
> The Society's growth reflected not only superb propaganda and organisation but its own success. The decline in infant mortality provided the most convincing evidence of the society's achievement.

The character of The Royal New Zealand Plunket Society has evolved over the years. At first it appeared to be insulated against change, but from the middle of the 1950s there were dramatic changes (Parry 1982:134). Parry's (1982:147) description of the effects of these changes appears to parallel what is happening within the Society today: "Some of them [the changes] came faster than the professionals in the field would have liked, some of them left the voluntary workers for the Society just plain bewildered." But, as Parry (1982:147) points out, amongst the volunteers the executive style also changed:

> The earlier Presidents had tended to be ladies of goodwill with time and talents to spare but with a clear idea of the importance of their office. Even as recently as Lady Bodkin there had been a tendency to drive rather than to lead. Jocelyn Ryburn began a sleeves-rolled-up style which others were to follow. Joy Reid and Joyce Andrews were both natural leaders but showed themselves sensitive to the viewpoints of others, to the aspirations of people at branch level as well as to opinions of members of Council and Executive.

By the mid 1970s Plunket had become more liberal and more democratic and by the end of the decade with an extensive network of branches and sub-branches the Plunket Society had become big business (Parry 1982:151):

> ...raising something like a million dollars a year and receiving about three times that amount in various forms of Government assistance. The time had come to assess the quality of administration as well as the nature of the service offered. A firm of business consultants was called in to take a long hard look at the structure of the Society.

The changes that ensued involved the Executive becoming representative of the whole country instead of being composed solely of Dunedin members. A triumvirate of Directors, from the fields of Medicine, Nursing and Administration, was formed to head the staff (Parry 1982:151). The Directors were responsible to the Executive who administered the policy. Looking back on the history of Plunket, Parry (1982:13) sums it up as follows:

> The Plunket Society is unique. Founded for the express purpose of filling a void in the New Zealand health service, it has demonstrated that a voluntary agency can make its influence felt to a degree unequalled by any organisation controlled and directed by the State. It has attracted and held the interest and energies of people at all levels of society, has reached into the farthest corners of the country, and has pointed the way to child welfare organisations in many parts of the world. Plunket has been, for the past 75 years, an integral part of our health system.

Organisational Structure

The Royal New Zealand Plunket Society has both voluntary and professional divisions, with volunteers forming the executive body of President, New Zealand Executive and Council. At the end of 1991, on the volunteer side, Council membership came from branch level, with each branch electing two representatives. Council was required to encourage and monitor the work of the Society, and councillors were appointed to the New Zealand Executive to represent each Plunket district. Past directors of medical and nursing services have been directly responsible to the Executive which was the governing body (see Figure 1). As reported by Norton (1990:33) there appeared to be a discrepancy in the level of influence held by the two directors:

> Although the Director of Nursing Services and the Director of Medical Services hold equal positions within the structural organisation, discussions with nursing and medical people and with people involved in the voluntary organisation suggest that the Medical Director is regarded as the principal professional person. Media coverage, in particular television reporting supports this notion. Whenever a comment on Plunket nursing is required it is the Medical Director, rather that the Director of Nursing Services, who makes the public announcement.

However, the structure and power relationships within The Royal New Zealand Plunket Society were in the process of re-organisation. In February 1992, a transitional

manager was employed until the end of June. The two Directors, nursing and medical were to lose management responsibilities and instead be responsible for policy development, professional leadership and supervision. A chief executive was appointed in August 1992, and regional managers soon after. Area manager positions have now been filled.

At the time of writing, a Plunket Society Board sets policy for The Royal New Zealand Plunket Society, the Directors of Child Health Policy, Nursing and Corporate services advise the Chief Executive and the Board, and the organisation is divided into four regions corresponding with the four Regional Health Authorities (see Figure 2). With the Plunket Society Board fulfilling the functions of the former Council, it seems that the relationship between the volunteer and professional sides of the Plunket Society remains fundamentally unchanged. Norton (1990:35) was concerned that this relationship impacted on the Plunket nursing service in negative as well as positive ways.

Currently, The Royal New Zealand Plunket Society still has national, regional and local structures, but this could change in July 1994 with a loss of a national identity as the re-organisation of the health system into four separate regions and the withdrawal of national funding becomes a reality. When the interviews occurred, Plunket nurses' salaries were fully subsidised by Government, while the cost of new vehicles received a 40 percent subsidy. All other costs were met through fundraising by the voluntary arm of the Plunket Society.

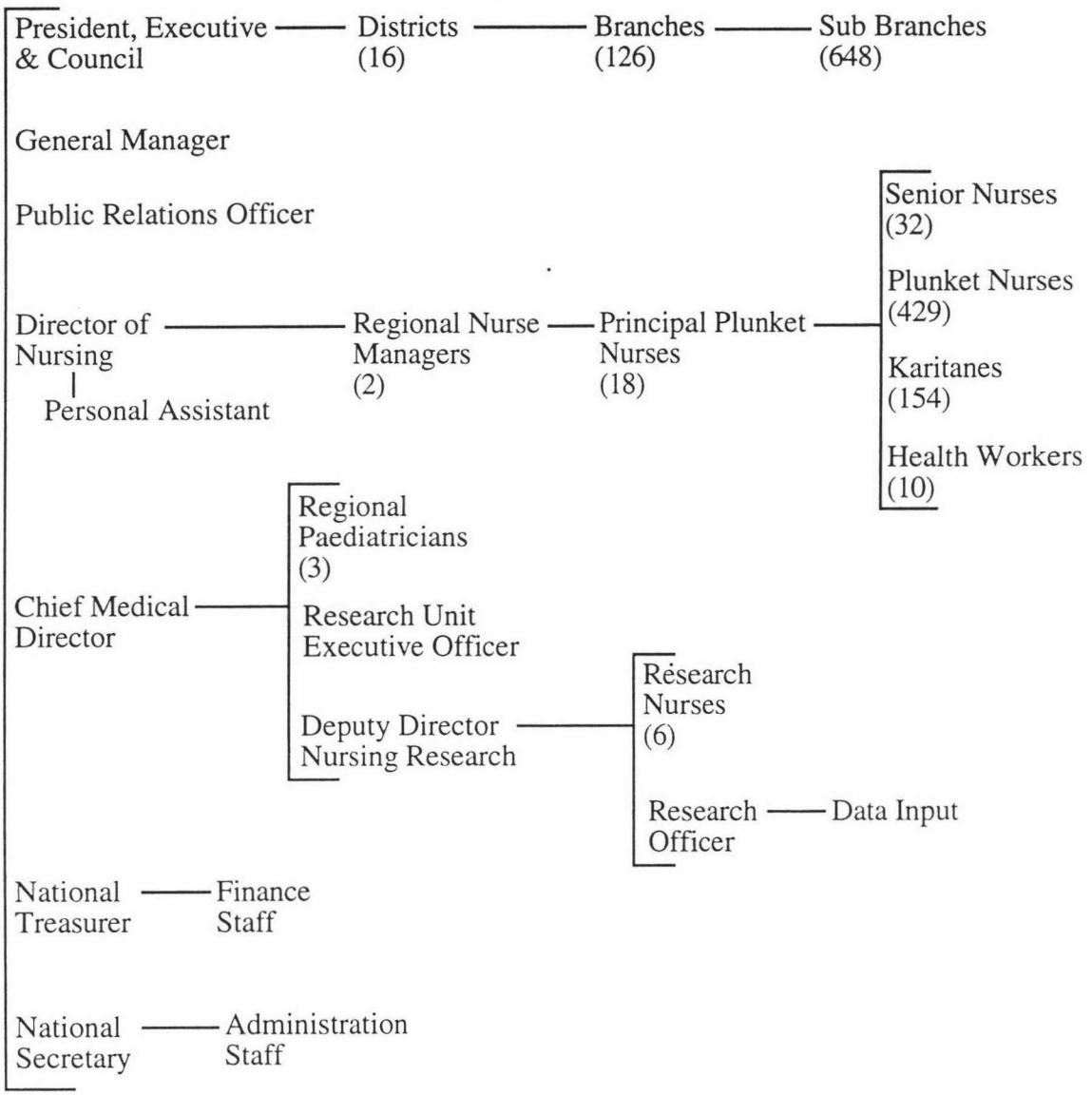

Figure 1

Plunket Organisation Chart as at 11 November, 1991

Source: The Royal New Zealand Plunket Society, Head Office (personal communication).

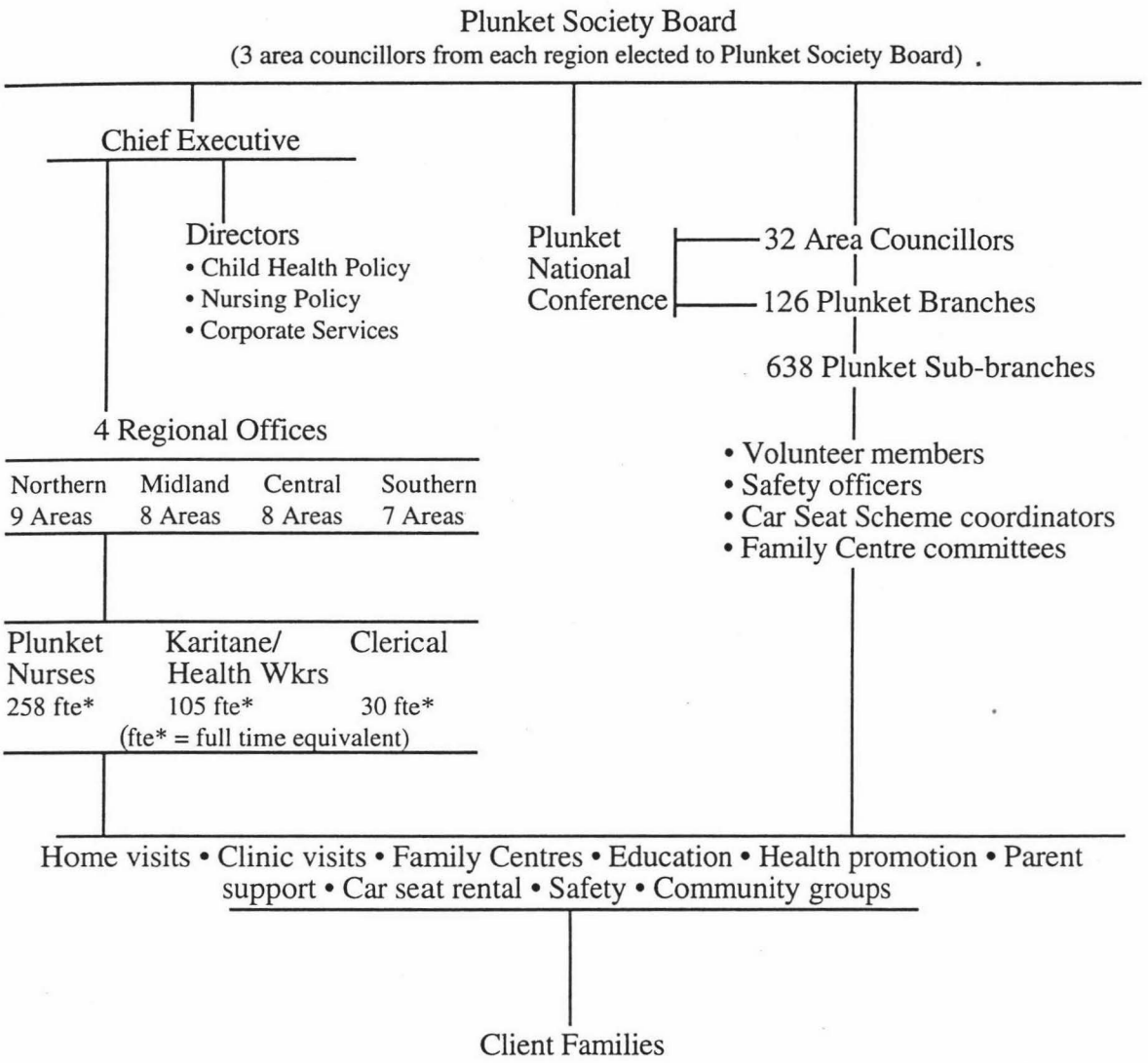

Figure 2

Structure of The Royal New Zealand Plunket Society April 1993

Source: The Royal New Zealand Plunket Society, Head Office (personal communication)

Relevant Studies

The Research and Education Unit of The Royal New Zealand Plunket Society has undertaken a variety of investigations in relation to the goals of the Society. There have also been some independent studies investigating the work of the Plunket Society, but none have had the standpoint of Plunket nurses as a main focus. The studies that have the most relevance to this thesis are those which investigated the relationship between Plunket nurse and Plunket service user.

Geddis and Silva (1979:507) found that the majority of the 982 mothers who responded to their survey considered the Plunket nursing service to be of some help. They (Geddis and Silva 1979:508) conclude: "On the basis of this study the Plunket Society has the dual benefit of being widely used and widely accepted." But the people participating in this study were on the whole socio-economically advantaged (Geddis and Silva 1979:507). Therefore, this study reflects only on the relationship between Plunket nurse and service user when both parties are socio-economically advantaged.

In other studies, more representative of the general population, the Plunket Society was not found to be so widely used or accepted. For example, Fergusson, Horwood, Beautrais and Shannon (1981:53) found: "A highly significant association between social background and the utilisation of preventive health care." In a second study, Fergusson, Beautrais and Shannon (1981:294), noting that "satisfaction with Plunket nurses was related to maternal social background," expressed concern that "...the families who would have benefited most from Plunket assistance were those least impressed with the service." Salmond (1975), Briggs and Allan (1983), Ford et al (1990) and Norton (1990), surveying levels of 'consumer' satisfaction, all found support for Hart's Inverse Care Law, which states that those with the greatest need receive the least care (Hart 1971).

In 1972, Salmond (1975) explored the nursing services offered to mothers with infants in both an inner city and a 'low status satellite' area of Wellington. Describing the Plunket Society as "part of the very back-bone of middle class New Zealand society," Salmond (1975:75) continued:

> From its beginnings...the society has evolved as a result of the community consciousness and voluntary efforts of middle class New Zealanders. Naturally services have evolved to meet the needs of the Society's strongest supporters—middle class New Zealander mothers. This fact is clearly demonstrated by the study.

Salmond (1975:70-72) concluded that his study suggested that the Inverse Care Law applied to all health services provided for infants and their mothers from the time the pregnancy was known, in the Wellington area in 1972. Of the Plunket nursing service at that time, he (Salmond 1975:76) wrote:

> To many mothers in a working class racially mixed community the whole philosophy which underlies Plunket care may be unintelligible...Many traditionally trained Plunket nurses must find it difficult to communicate with and to relate to the needs of working class mothers.

Salmond described Plunket nursing services, in the areas surveyed, as most acceptable and accessible to mothers from the middle and upper classes. He compared public health nurses favourably with Plunket nurses (Salmond 1975:76):

> The background of the public health nursing service gives the agency's nurses an advantage when dealing with Polynesian mothers. PHNs seem to have gone some distance towards bridging the gap between the providers and the users of services. Their wider concerns with the full range of family health problems and the fact that all care is given in the home are probably additional advantages.

Continuing the comparison, Salmond (1975:77) commented with regard to Plunket nurses, unlike public health nurses, that "few other health care professionals can be so isolated."

In a follow-up study in 1978, Briggs and Allan (1983:69), though finding some support for the Inverse Care Law, also reported improvement in access:

> Coverage by the nursing services (Plunket and public health) had improved from 1972 to 1978 for unmarried mothers living in a stable relationship, for Pacific Island mothers and for mothers from the low status satellite area. However, coverage declined for unmarried mothers in a solo situation and for mothers living in the city core area.

It was found (Briggs and Allan 1983:69) that mothers living in the low status satellite area were "much more satisfied [with the Plunket Nursing Service] in 1978 than in 1972," and were receiving "many more home visits from the Plunket nurses," which alleviated some of their transport difficulties as reported in the earlier study. Briggs and Allan (1983:75) reported also: "In 1972 some mothers remarked on old-fashioned advice and authoritarian [Plunket] nurses—few mothers in 1978 commented along these lines." They (Briggs and Allan 1983:75-76) added that, given the trend for more married women with families returning to the workforce, there may well have been more Plunket nurses who were experienced mothers with first hand knowledge of child-rearing in 1978 than in 1972. According to Briggs and Allan (1983:75) the improvements noted could have been brought about because the Plunket Society had: regionalised the 17-week course for registered nurses leading to the Plunket certification; incorporated new social emphases on child development into the course; and introduced, in 1975, re-orientation courses for Plunket nurses who had been practicing for more than four years. While recognising these developments, Briggs and Allan (1983:75) raised further questions:

> Have there been changes of the administrative heart that have filtered down to the grass roots level, so that mothers have received more and better services? Or has it been a case of dedicated workers in the field, without much support from the higher levels of administration, initiating changes they felt were necessary? Have certain rising expectations of mothers, traditionally the passive consumers of whatever service providers saw fit to offer, caused them to voice demands more strongly than before?

Other factors to be considered (Briggs and Allan 1983:75-76) included a declining birthrate, as well as an increase in the Plunket nursing workforce of between one-quarter to one-fifth over the period 1972 to 1978. Furthermore, it appeared that Plunket nurses were putting extra effort into home visiting in order to re-establish contact with mothers who were not keeping clinic appointments. This area of Plunket nurse activity had increased, while routine home visits and clinic consultations had decreased. They (Briggs and Allan 1983:76) speculate:

> The time-consuming visiting to re-establish contact probably involves very few mothers of babies less than six months old. However, it may well have paid off, if these mothers were the unmarried mothers...,or the Pacific Island mothers, or the large proportion of low status satellite mothers who increased their share of Plunket services between 1972 and 1978.

Overall, the Briggs and Allan study revealed a changing Plunket nursing service, one that had become more accessible and acceptable to a wider range of people.

Closure of residential Karitane hospitals between 1978-1980 and the introduction of community-based family support units—staffed by both Karitane and Plunket nurses— represent an attempt within Plunket to more effectively meet social needs. Clarkson et al (1985:807), evaluating these units in Dunedin, found "a high level of consumer satisfaction." They (Clarkson et al 1985:809) concluded:

> ...the finding in this study that the units catered at least equally for all socio-economic classes provides some reassurance that attempts to provide care where it is needed are beginning to be successful.
> ...presenting problems were managed efficiently in terms of the number of visits and other health care resources consumed, and effectively in terms of the opinions of the providers and users of the service. Unit staff were quick to recognise when a problem should be referred to another agency.
> ...We have shown that the family units are fulfilling a community role which is not being met from other sources. The service provided is valued by the people who use it, and it offers an effective management of the range of problems in families who are referred.

Clarkson et al (1985), then, described a service which was effective and appreciated by those using it.

However in 1990, there was still reported evidence that Plunket nurses were not reaching many of those with the greatest need. For example, in a study of the pattern of contacts with Plunket nurses in the first year of life in the Christchurch area, Ford et al (1990:317) found:

> ...the home visits were the best kept contacts...those infants identified as high risk...were the very children least likely to attend Plunket. Thus the most vulnerable infants have the least contact with routine child health surveillance during the period of this study.

Norton (1990:ii) distinguished between 'health care' and 'health services' by using 'health care' to refer to "the on-going 24-hour-a-day involvement in health work performed by people without professional health qualifications for members of their household, relatives and close friends," whereas 'health services' referred to "the health work performed by those employed within the institutional framework of the organised health system." Her study had three areas of focus: mothers as providers of health care for their babies; the relationship between those who provide health care and those who provide health services; and access to health services. The health services she investigated were those of some Plunket nurses working in Christchurch in 1988, and she viewed her results in relation to the Inverse Care Law. She (Norton 1990:2) wrote:

> In order to address the issues involved in access to health services we must be able to explain the experiences of those who use the services. Only then can the services be developed in accordance to the needs of the people who use them.

Summing up, Norton emphasised the support that she found for Hart's Law, but noted also that some nurses were more flexible than others in reorganising their practice to maintain contact with mothers who were not keeping appointments (Norton 1990:163). Furthermore, she (Norton 1990:163) observed that there were constraints, originating within The Royal New Zealand Plunket Society or the Department of Health, on Plunket nurse. She concluded that the problem of access to Plunket's nursing service needed to be addressed at an individual level, at the administration level, as well as within the Society's relationship with the Department of Health, which is where the allocation of funding was negotiated.

The results of these studies suggest that Plunket nursing services have not reached those in greatest need, in the past, but that these services were becoming more flexible, and nurses less isolationist. More specifically, Briggs and Allan (1983) found increasing use of Plunket services by a broader range of people, Clarkson et al (1985:809) found that the Inverse Care Law did not apply to services offered in Plunket family units in Dunedin, and Norton (1990:163) reported that some Plunket nurses were reorganising their practice in order to reach people who found it difficult to keep clinic appointments. Significantly, Norton (1990:163) concluded also that problems of access related to problems within Plunket and Government structures. Finally, it is possible that there are regional variations in the effectiveness of Plunket nursing services. It is highly probable that if the two studies conducted in the Christchurch area

(Norton 1990; Ford et al 1990) had occurred elsewhere, the results would have been different. A further follow-up in the Wellington area, given the trends reported by Briggs and Allan (1983), would be of value.

Plunket Nurses and Public Health Nurses

A theme throughout the literature concerns the relationship between the child health services offered by Plunket nurses and those offered by public health nurses. Raffle (1977:8) commented that these dual child health services were the source of "one of the most persistent and spirited health controversies in New Zealand." Although the work was supposedly identical, following the same pattern of consultation, the philosophies were different. Public health nurses did not inherit the philosophy set out by Truby King and originally their practice was mainly rural. The Board of Health (1982:215-216) reported that at the end of the 1970s:

> Involvement of PHNs (public health nurses) with the under five age group varies considerably within and between regions. This relates to demographic and social trends, historical factors, and departmental programmes for special 'at-risk' groups. PHN involvement is generally higher in the North Island and in health districts which have traditionally had a high rural and Maori population. In 1979, the proportion of infants supervised by PHNs as a percentage of all live births was highest in Whangarei (54.6 per cent), Gisborne (56 per cent) and Hamilton (31 per cent), and lowest in Christchurch (1 per cent), Dunedin (2.1 per cent), Invercargill (6.6 per cent) and Lower Hutt (6.1 per cent).

Briggs and Allan (1983:31)noted:

> Within the country there has always been some variation in terms of which nursing agency had the major share of the infant nursing workload. Some rural areas with a high Maori population, for example, have almost complete coverage by the public health nurse. More established urban areas have usually been serviced exclusively by Plunket nurses. The newer and poorer areas, on the other hand have sometimes suffered from inadequate coverage by both agencies.

Briggs and Allan (1983:68) found a pattern similar to that of Salmond's (1975) study, with: 81 percent of mothers receiving Plunket nursing services, 9 percent seen by public health nurses and 7 percent seen by both agencies. The remainder—3 percent—received no care from either agency. Briggs and Allan (1983:69) further delineated the differences between Plunket and public health nursing:

> As in 1972, Plunket nurses tended to provide care for women where the head of household was in a professional or administrative position, whereas public health nurses visited mainly women in households where the head was in semi skilled or unskilled employment or was a beneficiary.

By the early 1980s, the balance between the agencies was changing, with the Department of Health promoting the use of Plunket services where they were available. A policy decision involved the provision by Plunket of **all** infant and pre-school preventive health services in the South Auckland area (Briggs and Allan 1983:31). This echoed the Board of Health (1982:229) recommendation:

> We believe it is practical to promote a dual nursing service, with the Plunket Society carrying out the major responsibility for providing nursing services for the 0-5 age group, and the Department of Health public health nurse being primarily involved with the school age component of child health nursing services.

At the present time (1993), public health nurses are employed by CHEs, and they continue to provide child health nursing services for children under five years, but only in a few places. In the majority of areas, this work is the sole domain of Plunket nurses.

Plunket and public health nursing are two examples of the diversity of nursing. Both have a health focus, both are situated within the community, and both share their origins with hospital-based domiciliary nursing.

The Development of Nursing

In order to further develop the social context of the nurses who participated in this study, I will trace those aspects of the evolution of nursing that are most relevant to Plunket nurse practice today. I will begin with developments that occurred in the nineteenth century, because it was during this time that nursing (as it has been practiced this century) was established. I will draw from the literature of a number of different countries, all of which have nursing systems with origins and development similar to that of New Zealand.

During the nineteenth century the 'curing' and 'caring' functions within health services were separated, with the former allocated to male doctors and the latter to female nurses (Versluysen 1980:188). Pascall (1986:188) argues:

> The most obvious gender division in the health labour force is between male doctor and female nurse. The sex-role stereotyping is plain: father/mother, decision-maker/assistant, earner/houseworker, with 'pin-money'/wages, intellect/emotion, cure/care.

Pascall (1986:189) equates the gender division of doctor and nurse to that within the bourgeois family, with head nurse playing a role similar to that of female authority over household servants, but under a husband's command. Abel-Smith (1960:25) quotes from a letter written by Nightingale in 1867:

> The whole reform in nursing both at home and abroad has consisted in this; to take all power over the nursing out of the hands of the men, and put it into the hands of **one female** trained head and make her responsible for everything.

Yet, this one female authority remained answerable to a higher medical authority, and by the end of the nineteenth century an exclusively male medical profession had ascendancy over female healers (Pascall 1986:182). Perhaps no alternative was possible at that time. Medicine was equated with science. Rather than caring for the sick, doctors were interested in describing signs and symptoms, making a diagnosis and prescribing treatment accordingly. Pascall (1986:189) describes the specialisation and elite status of medical men, at that time, as requiring the development of more humble occupations.

However, as well as setting up nursing under the umbrella of medicine, Nightingale organised a hierarchical class system with its own over-all autocratic authority. As late as 1983, Iveson-Iveson (1983:27) maintained, "Nurses have not learned to discard the Nightingale model of administration." This system established class distinction in nursing with one authority at the top, kept the number of nurses within hospitals to a minimum, and was characterised by rigid discipline with the expectation of complete obedience (Iveson-Iveson 1983:27). Women (registered nurses) trained other women (student nurses) to comply. From the lowest ranks of a rigid, autocratic hierarchy, it is difficult to act as advocate for someone even more powerless, namely a 'patient.' It is also difficult to find a channel for effective protest, for as Cartwright (1988:172) commented:

> Nurses who most appropriately should be the advocates for the patient, feel sufficiently intimidated by the medical staff (who do not hire or fire them) that even today they fail or refuse to confront openly the issues arising from the 1966 trial.[3]

From my experience, I have found that nurses are socialised into a culture which specifies that: a nurse has less credibility than a doctor, and therefore, a nurse does not challenge a doctor; a doctor decides how much information and what kind of information a patient receives, and therefore, a nurse must not give a patient information without a doctor's consent. Since nurses are close to the bottom of a power hierarchy, their objections have little chance of receiving a just hearing. As recently as the late 1980s, Coney (1988:240) quotes Stephanie Breen (representing the Nurses' Union) as saying:

> All decisions and policies are made by male-dominated administration and male-dominated medical professionals. Nurses are powerless in this situation...Nurses become acculturated into that culture and if things happen often enough and frequently enough, then maybe it is seen to be all right.

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[3] In this quote the word 'trial' refers to an experimental study not a legal inquiry.

Within the culture of the hospital, obedience is valued and the roles of doctor, nurse and patient are firmly fixed. The 'patient,' the person on the receiving end of health services is even more powerless than those at the bottom of the professional hierarchies.

Social hierarchies serve to separate those at the bottom from those at the top. The people with the most power are shielded from those who have the least by those in the middle. Those who have the least power have least access to those who hold the most and the people in between act as a buffer to protect those at the top. Nurses often end up pacifying a patient who has been treated badly by a doctor, instead of trying to redress the wrong. In this way, nurses serve to reinforce doctors' power and status. In an Australian study (Buckenham and McGrath 1983:vii) set up to investigate the discrepancy between what nurses were taught and what they practiced, it was found that while registered nurses recognised that their role embraced that of patient advocate, they saw their main function as one of assisting and supporting the doctor. When they were faced with choosing between acting as patient advocate or loyalty to a doctor, they chose the latter (Buckenham and McGrath 1983:96). However, Buckenham and McGrath (1983:97) found also that nurses were very conscious of their subordinate status, and that when they did attempt to act as advocate for those using their services they experienced frustration and powerlessness: "You can't do anything, really"; "There's not much point saying anything to the doctor. They just do it again next time"; "Even if you do say something, they just shrug it off." The researchers (Buckenham and McGrath 1983:104) concluded:

> ...it seems that the notion of subordination represents a disproportionate element of the student's perception of the reality of the hospital world...as a beginning student she is presented with an image of herself as a subordinate member of a subordinate division of the health team. Throughout the three years of her training...that image is consistently corroborated by all those who are significant in her socialisation. The student nurse rapidly becomes cognisant of the fact, the reality, that both her acceptance into, and continued membership of, the health team depend upon her manifest recognition of her subordinate status within that team...it may not be overstating the case to say that the student nurse's training represents a grooming for a career in subordination.

Some parallels with the Australian study of Buckenham and McGrath (1983) were revealed in a New Zealand study by Perry (1985:85):

> In both the polytechnic and the hospital, an ideology of consent masked the social structures which produced contradictions between the graduates' education based ideals and beliefs, and the exigencies arising from clinical experience and hospital practice. In this way each graduate was inclined to give a self-effacing rationale for her apparent inability to validate her personal and professional judgements in the practice setting. The graduates reported many instances in which they had attempted to use personal or professional judgements but had complied with those practices, principles and beliefs which

> they had perceived to be desirable by people who held the power to determine their future. They learned to act in accordance with what they perceived was expected of them. In this way established professional nursing culture became an integral part of these graduates' understanding of what it means to be a student or a graduate nurse.

In both the Australian and the New Zealand studies there were indications that the degree of compliance and the lack of focus on contextual social structures demonstrated by nurses originated with their basic nursing education. Perry (1985:86) found that the nurses in her study "had little opportunity to formally distance themselves from aspects of professional culture and to formally reflect upon its effects on their personal and professional lives." She (Perry 1985:86-87) wrote:

> This incapacity for formal critical self reflection allowed these graduates to perceive forms of social domination as personal inadequacies in their own professional competence...although these graduates realised, to some extent, that social structures constrained their actions, they did not recognise their ability to challenge or change those same structures. The epistemic conditions necessary for emancipatory knowledge which would enable the graduates to transform these structures were not present either during their education or in graduate practice.

It would seem that nursing culture in New Zealand has changed little since Reid (1965:12) commented on it in the mid-sixties:

> We learn our professional role from our professional education, and where that education is narrow, traditional and traditionally hierarchical, the chances are that so also will be those who are products of it.

Lumby (1993b:4) writes of nurses as being, "identified with obedience, selflessness, virtue and hard work as well as rigidity of approach."

Perry (1985:87), describing the approach to nursing education and practice as 'instrumental,' wrote that the nursing curriculum, at the time of her study, was dominated by a technical linear paradigm. She (Perry 1985:85) argued:

> An ideology of individualism, predominant in both education and practice, masked the social conditions which produced feelings of personal inadequacy, as well as masking the social conditions of producing self-blame.

Perry (1985:87) concluded that as a result, "existing professional nursing culture is reproduced in graduate practice and ideological hegemony is maintained." Similarly, on the theme of personal inadequacy, Buckenham and McGrath (1983:105) describe a student nurse as "subjected to a system which demands deferential and subordinate behaviour, which teaches her to consider herself subservient."

Although one of the nurses in the Buckenham and McGrath (1983:99) study said, "It will never change," changes are occurring. For example, I remember the New Zealand Nurses' Association as a conservative group that supported rather than

challenged the status quo. Now, people from the New Zealand Nurses' Organisation[4] speak out about social policy in order to advocate for safe health practices and reasonable working conditions. As reported in *The Dominion* (26 June 1993), nurses, in order to retain their conditions of employment, have confronted the organisations which employ them. Furthermore, representatives from the New Zealand Nurses' Organisation have requested the International Council of Nurses Congress to support a resolution condemning New Zealand's Employment Contracts Act and calls for the New Zealand Government to develop a new and fairer law.

There are changes also in schools of nursing. Lumby (1993a:1) discussing these began by quoting Einstein (1973:80):

> Knowledge exists in two forms...lifeless, stored in books, and alive in the consciousness of men. The second form of existence is after all the essential one; the first, indispensable as it may be, occupies only an inferior position.

With reference to nursing, Lumby argued that knowledge alive in the consciousness of women (and men) has a particular pertinence for nurses. She saw congruency between practice, research and education as a necessary condition for this kind of knowledge. She said that if nursing practice, research and educational process were not congruent, nursing knowledge would be lifeless, stored in books, and would never live in the consciousness of others, including the consciousness of future generations of nurses. She described the changes occurring in nursing education as a movement away from the 'banking' concept of education towards a student centred approach. Lumby (1993a:9) writes:

> We need to ensure that our curricula reflect the reality of practice, the contexts in which the practice occurs and the society which determines both the discourse and the financial structures in which our practice operates. If we focus only on the actual competencies of the practitioners, we run the risk of graduating nurses who become disillusioned because of the constraints of the social and political context in which health care is carried out...we can at least prepare them (nursing students) to be reflective practitioners able to look critically at what is happening around them. This critical consciousness enables alternatives to be envisaged and thus future practices to be viewed not as fixed structures but as changeable and therefore controllable within certain parameters.

In this way Lumby presents a solution to the situation which Perry (1985) and Buckenham and McGrath (1983) found in their studies as cited above. As part of this solution, Lumby (1993b:8-9) points to the more explicit focus that nurses are placing on caring.

In the past, the focus has been on what is highly visible. Nursing has been task oriented, instrumental. Now, schools of nursing are changing their curricula to fit with

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[4] The New Zealand Nurses' Association and the Nurses' Union joined to form the New Zealand Nurses' Organisation on 1 April 1993.

a philosophy of caring (for example, see Bevis and Watson 1989). Lumby (1993a:4-5) places the invisibility of nurses' work within the invisibility of what has traditionally been seen as women's work; namely, the caring for others at home. More recent research makes visible what has been invisible, that is the elements of the relationship between nurse and 'patient' (eg: Christensen 1990). Lumby (1993a:7) argues:

> ...the values inherent in the way nurses relate to people in their daily work are those of ensuring safety, trust, authenticity and reciprocity within their relationships so that the one who is cared for retains personal integrity. This is vital for people who feel vulnerable and powerless in their illness and for those particularly sensitive to pretence and dishonesty in their instability. We need to ensure that our practice, research and our curricula reflect these values and attributes.

The 'patient' is being rescued from the margins of the health system and brought into equal relationship with the nurse as caregiver. No longer external and inferior, 'the patient' is seen as part of the health team (see Buckenham and McGrath, quoted above). Quality of relationship is being recognised as central to health.

RELATIONSHIP

Geering (1983:27) writes:

> To be a human being one must learn how to say both I-Thou and I-It, but in such a way as to keep the two worlds in a healthy balance. To the extent to which the It-world is allowed to squeeze out the world of relation, to that extent humanity itself is endangered, even to the point of extinction .

Sartre (1947; 1956) described three forms of being, including a Being-for-Others. Although he sometimes described Being-for-Others positively as communal, he was more inclined to describe it negatively as (Sartre 1947:115) "a perpetual conflict as each For-itself seeks to recover its own Being by directly or indirectly making an object out of the Other." Sartre (1956:364) writes of a power struggle between the Self and the Other:

> While I attempt to free myself from the hold of the Other, the Other is trying to free himself from mine; while I seek to enslave the Other, the Other seeks to enslave me...Descriptions of concrete behaviour must be seen within the perspective of *conflict.*

Sartre's use of 'Other' is similar to Buber's (1958) use of 'It.' Buber distinguishes between I-Thou and I-It relationships. In the latter, the person who is I sees the other person as a thing to be used or possessed, whereas in an I-Thou relationship the person who is I respects and loves the person who is Thou. The dichotomy between I-Thou

and I-It—between relationships based on community and relationships based on competition—is reflected in the social science literature.

Family therapists are directly concerned with relationship, and they, like Sartre, tend to see relationship in terms of conflict over power. Family therapists describe two types of relationship, **symmetrical** and **complementary**, neither of which corresponds with Buber's description of I-Thou (Barker 1986:48; Goldenberg and Goldenberg 1985:62-67). Participants within a **symmetrical** relationship are seen as being on an equal footing, but as competing with each other. If one tries to dominate, so too does the other. This is similar to the relationship described by Sartre (quoted above). Conversely, **complementary** interaction has a basis in inequality. One participant is dominant, the other submissive. This kind of relationship could have begun symmetrically with both participants struggling for control over the other, but it has ended with one gaining dominance. Goldenberg and Goldenberg (1985:66) interpret Haley's (1963:4) argument: "When one person communicates a message to another he is manoeuvring to define a relationship," as "every communication reflects a struggle for control of a relationship." Barker (1986:49) also refers to Haley (1963; 1976) when stating: "Creatures of any sort who are organised together make up a status, or power, ladder." These writers appear to see relationship in terms of hierarchy and power.

However, Barker (1986:49) allows that there may be a coalition between members at different levels within a hierarchy, and Goldenberg and Goldenberg (1985:65) admit the possibility that symmetrical relationships can also be based on equity when difference is minimised. If 'minimised' means 'seen as acceptable' or 'valued,' this last proposition allows for the possibility of relationships of reciprocity in which power struggles are not an issue. Bateson (1972:68-72), among the first to study patterns of communication, uses the terms 'symmetrical' and 'complementary' as above. However, he also allows for a third type of relationship which does not tend toward schism. He calls this relationship 'reciprocal.' A reciprocal relationship seems similar to what Buber (1958) calls 'I-Thou,' or simply, 'relation.' Geering (1983:16) describes relation as:

> . . . a mutual reaching out of life to life. . . . It is not a force or movement which works only in one direction. There is a two-way attraction. There is a mutual response. There is an encounter, the one with the other and the other with the one, a genuine meeting. . . . it involves the whole of whatever is at each of the two poles of the encounter. It is not just a part which is involved.

This kind of relationship is based on truth, trust, respect and love. Satir (1972:59-79) describes five communication styles. Of these five styles only one is direct, free from attempts to dominate. Satir calls this 'levelling' and her descriptions of it correspond to descriptions of the I-Thou relation. Within relation, participants have equal status and there is respect for the Other as there is for the I. This resonates with Alvarez (1983:25)

writing about social hierarchies: "The treatment that we want from the ups, when we are down, is what we are obligated to guarantee for the downs when we are up."

It is possible for two or more people to meet on the level. That is, people can meet without trying to exert power over each other. Regardless of the culturally defined status of the people involved, interaction can be based on co-operation rather than competition. Therefore I disagree with the absoluteness of the statement attributed to Haley ("every communication reflects a struggle for control of a relationship"). Yet, as perceived by Buber (1985:17), relationship is fluid:

> Every *Thou* in the world is by its nature fated to become a thing, or continually re-enter into the condition of things. In objective speech it would be said that every thing in the world, either before or after becoming a thing, is able to appear to an *I* as its *Thou*. But objective speech snatches only at a fringe of real life.

The quality of interaction changes from moment to moment, but over time a particular relationship is likely to show a dominant pattern. Where that pattern reflects mutuality all parties are carrying responsibility for the relationship. They are 'in relation.'

'Western' cultures are characterised by social hierarchies which are composed of patterns of one-up one-down relationships, and one-up one-down relationships have the potential for the most abuse (Grundy and Weinstein 1974:49-54). Yet, as with other aspects of society, one-up one-down relationships tend to be the norm within the health system. Barker (1986:48), discussing the unequal footing of complementary relationships, points out that these relationships often conform to the customs of the culture. He gives the doctor-patient relationship as one example, with the doctor in the dominant one-up position and the patient in the submissive one-down position. He makes no suggestion that this is problematic.[5] In Buber's (1958) terms, practice within health professions has tended to be in the I-It mode, with the professional as I. When Ferguson (1982:270-271) lists the assumptions underlying what she calls the "old paradigm of medicine" she describes a complementary relationship; an I-It relationship. Donzelot (1979:171) uses the phrase, "technicians in human relations" for "those who intervene in the lives of families in order to educate members and repair faults." He (Donzelot 1979:103) writes of the family as colonised: "There are no longer two authorities facing one another, the family and the apparatus, but a series of concentric circles around the child: the family circle, the circle of technicians, and the circle of social guardians."[6]

Like Howe's (1989:10-11) analysis of the effects of new technologies and styles of management within practice with families, this quote of Donzelot's echoes the

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[5]The fact that this type of relationship is the norm could be one reason why writers like Barker and Haley appear to find it difficult to see relationship based on reciprocity as a possibility.

[6]Norton (1990:163) cautions against the tendency on the part of health professionals to discount mothers' understanding of their children's health.

panopticon analogy put forward by Foucault (1979:200-228). Briefly, the panopticon is Bentham's[7] plan for a guard house designed to ensure that all occupants feel that they are under continuous surveillance. Foucault (1979:207-208) offers an historical analysis:

> The celebrated, transparent, circular cage, with its high tower, powerful and knowing, may have been for Bentham a project of a perfect disciplinary institution; but he also set out to show how one may 'unlock' the disciplines and get them to function in a diffused, multiple, polyvalent way throughout the whole social body.
> ...The movement from one project to the other, from a schema of exceptional discipline to one of a generalised surveillance, rests on a historical transformation: the gradual extension of the mechanisms of discipline throughout the seventeenth and eighteenth centuries, their spread throughout the whole social body, the formation of what might be called in general the disciplinary society.

According to Foucault, the essential ideas of the panopticon were embraced as a technology of power, which acted as a web of control, shaping our social structures. He (Foucault 1979:211-218) traces the emergence of a number of "disciplinary mechanisms," from the closed fortresses of prisons, hospitals, armies, monasteries, schools, stating that "the massive, compact disciplines are broken down into flexible methods of control, which may be transferred and adapted." They "can circulate in a 'free' state." Foucault (1979:223) argues that the panopticon made possible both the rise of capitalism and the social sciences: "...[the human sciences] characterise, classify, specialise; they distribute along a scale, around a norm, hierarchise individuals in relation to one another, and if necessary, disqualify and invalidate." According to Foucault (1980:156), even those who inhabit the guard house are watched: "This is the diabolical aspect of the idea and all the applications of it. . . It's a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised."

There is agreement amongst the writers quoted in this section that people and relationship are becoming more and more objectified in 'Western' cultures. Buber (1958:37-38) describes this as, "the progressive augmentation of the world of It." As a consequence there is a loss of humanity; a loss of rights. Management of people has become a major activity. Within universities, courses in human resource management are offered. Within health and welfare systems many nurses, social workers, family therapists, doctors and psychologists pressure people to comply with socially prescribed gender roles.[8] It appears that the phenomenon known as 'mother-blaming' is part of this trend.

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[7] In the eighteenth century, Jeremy Bentham developed the Panopticon as an architectural form. Foucault (1979) gives as a reference: "Bentham, J. *Works*, ed. Bowring, IV, 1843."

[8] A number of writers have found evidence to support this observation For example see Roberts (1985], Beecher (1986), Donzelot (1979).

As mentioned previously, The Royal New Zealand Plunket Society arose in a climate where women were blamed for their families' anti-social tendencies (Tennant 1989:123). The effects of poverty and male domination were not admitted. Beatson (1990:259) writes of a monologue, discernible over the last one hundred and fifty years in New Zealand, as:

> . . . conducted in the main from the point of view of middle class, male Pakeha. Their master narrative has pushed the working class, women and non-Pakeha into the margins of history. It has trivialised, stereotyped and not infrequently insulted them .

The dominant social narrative supported the approach and shape that the Plunket Society took, and the 'civilising' actions of Plunket Society members and workers, were replicated by many others in the 'helping professions' including health. Hourigan-Johnston and Robinson (1989:6) point out that mother-blaming is very common in articles in clinical journals. From their literature search they conclude that women have been conditioned by society to blame themselves. Women then, enter therapy feeling blamed, guilt-ridden and powerless. Beecher (1986) describes how many family therapists, claiming a position of neutrality, serve to reinforce the prevailing ideology of gender-power relations. The dominant narrative, which has women as inferior, represents the norm, and as such, is difficult to see. When health practitioners accept this narrative as part of their theoretical framework they also tend to see themselves as unbiased, as neutral, and they work to help people to adjust to their roles as prescribed by the dominant narrative.

This pattern was apparent in the philosophy which informed the development of The Society for Promoting the Health of Women and Children, in 1907. As a number of writers point out (for example, Parry 1982, Oliver 1988, Tennant 1989), this Society, in tune with the times, aimed for the enforcement of motherhood and domesticity upon women. Plunket nurses, as with other health professionals, were expected to take a one-up stance in relation to those using their services. Similar to other social institutions, the Plunket Society itself was characterised by social hierarchies.

Within a system composed of power hierarchies it is not easy for those in positions of power to create relationships based on reciprocity with those who hold less powerful positions. To establish relation might be difficult when we are awarded higher status, when the other person is disabled in some way or desires dependency, when everyone is watching and we are expected to conform. However, when women and men, working as health professionals, take on a parental role they run the risk of creating further dependency.

We learn who we are from the pictures others reflect back to us. I comprehend myself in relation with another. If I am abused continually, if I am the 'it' in an I-It

relationship, I cannot see my full humanity. The quality of relation **is** pertinent to health, because health cannot be separated from any aspect of self, life, or environment. In order to be effective, people working in health must work to create relationships which are based on equality; which are reciprocal and in which there is mutual respect. This is now happening in nursing as outlined above. Ferguson (1982:270-271) describes the quality of I-Thou relation as she lists the assumptions underlying what she calls "the new paradigm for health." In the I-Thou mode of existence we can feel the respect and regard the Other holds for us. Each encourages the Other to healthier states of being. The quality of relation **is** pertinent, not to cure, but to healing.

SUMMARY

In order to develop a social context for the nurses who participated in this study, I have discussed: the nature of the New Zealand health system, the development and structure of The Royal New Zealand Plunket Society, studies of the Plunket nursing service, the development of nursing and the nature of relationship. In my discussion of the New Zealand health system I emphasised the role of the medical profession. I did this partly because both the Nightingale school of nursing and The Royal New Zealand Plunket Society were set up under medical authority, but also because the medical profession has been extremely influential in shaping the development of the health system.

Though the Plunket service was set up under medical authority, Plunket nurses were answerable to an unpaid volunteer executive drawn from upper middle class women who also acted as fund raisers. Plunket nurses inherit a dual set of expectations (from nursing, as well as the Society) that they will train parents, mothers in particular, to discipline their children. In the past many nurses did adopt authoritarian attitudes toward the people using their services (Tennant 1989:123-124), but these nurses were widely accepted by New Zealand women (Koopman-Boyden and Scott, 1984:50). It seems that both nurses and mothers saw their roles in terms of a dominant narrative. Within this narrative women were diminished, stereotyped and seen to need to be controlled. Plunket nurses acted to reinforce these socially acceptable views articulated by King and others in the early 1900s.

In more recent years the Plunket nursing service has not been so widely accepted. A number of studies show that the Plunket nursing service was not reaching many of those with the greatest need, and it was argued that many Plunket nurses were not sufficiently flexible to be accepted by people other than those in the Pakeha middle class. On the other hand, there were indications that Plunket nurses **were** becoming more flexible, more acceptable to a wider range of people (Norton 1990:163), and less

isolated in their practice (Briggs and Allan 1983:79). As with nursing generally, the work of Plunket nurses appears to be evolving and approaching the WHO (1978) view of primary health care. Their practice is in accord with the new paradigm of health as outlined by Ferguson (1982:270-271).

The quality of relationship between the majority of Plunket nurses and the families using their services is changing. Within the discipline of nursing, including Plunket nursing, relationship is being seen as the key to effective practice. Schools of nursing are beginning to base their curricula on a caring rather than a behavioural model. The focus is becoming one of support rather than control and increasingly the relationship between a nurse and service user is becoming that of I-Thou rather than I-It. Increasingly, nurses are working to establish reciprocal, egalitarian relationships with those using their services.

CHAPTER 2

METHOD

Since I would argue that research is shaped by the underlying philosophy and beliefs of the researcher, I will begin with a discussion of my own approach, which could be described as 'feminist.' Certainly I owe much to feminist literature. However, I feel uncomfortable with the 'feminist' label, in that it appears to ascribe a particularity to women, apparently excluding men. While some men do describe themselves as feminist, not all who subscribe to feminist principles would. My father, who taught me the value of cooperation, tolerance and social inclusiveness, never saw himself as feminist. The principles (humility, faith, hope, love, trust and critical thinking) underlying Freire's work (1972:62-65), could well apply to feminist research. Thus Freire's ideas parallel feminist thought, and feminists search for research methods which 'conscientise' in Freire's (1972) terms. Furthermore, the interviewer-interviewee relationship advocated by Oakley (1981) is consistent with I-Thou relation as outlined by Buber (1958).

My approach to this study is firmly based on my view of reality, which is as follows. Social reality exists, and we are part of it, but what each of us describes as reality is our own interpretation of people, objects, events and relationships around us. That is, our descriptions of reality are beliefs about reality. However, we act on these beliefs as though they are real and thus through our behaviour we make them real. Different voices will express different views of reality, and each voice will contain some distortion. Content analysis of different perspectives will show areas of agreement and areas of disagreement. For example, we might agree that a particular social structure is hierarchical, but disagree about who holds the most power within it. Some views will build logically on others and some will give rise to anomalies. There are, therefore, many different versions of the truth. A group of people might find consensus on a particular issue or phenomenon at a given time and in a given context, but no one person will completely agree with another, and consensus will shift. What is perceived as 'truth' will shift. However, perceptions of truth can be made explicit and understanding of the human condition can be advanced. As our recorded view of social reality becomes more composite, integrating a variety of perspectives, a more detailed, more encompassing picture of the social territory—one with which a more diverse range of people and groups can identify—becomes more probable.

Finally, there is some confusion in the literature surrounding the use of the words 'method', 'methodology' and 'technique.' By distinguishing between

'method' (techniques for gathering data) and 'methodology' (a theory and analysis of how research should proceed) Harding (1987:2) begins to resolve some of the ambiguity. However, the word 'methodology' is clumsy, and the similarity of the two words remains confusing. I find it useful to extend the meaning of the word 'method' to include the entire scientific process, from choice of topic to presentation and utilisation of results, and to include the mode in which the research is conducted (see Bryson 1979). The word 'technique' can be reserved for how data is gathered. Hence I have called this chapter 'method,' and in it I will outline my approach, the process I have followed and my research technique.

I will begin with a discussion of qualitative and quantitative approaches within social science, giving my rationale for choosing the former for this study. This will be followed by an outline of the ethical issues involved and the ways that I have resolved them. I will describe the investigative procedures I have used, including the selection and interviewing of participants, data analysis, and other sources of data.

Approaches to Research

Writers of introductory social science texts often include a section on the traditional model of science presented as a series of steps. In the view of Atkinson, Atkinson and Hilgard (1983:173) the observational method is "the starting point of psychology." Within psychology the observational method is confined to observation, description and interpretation of naturally occurring behaviour. Atkinson, Atkinson and Hilgard (1983:173) argue: "The early stages of science necessitate exploration to become familiar with the relationships that later will be the object of more precise study." However, in a later text Kalat (1990:21) presents the formation of a hypothesis as the first step within the scientific model. "In many cases," Kalat writes, "the hypothesis is the product of someone's casual observation." Babbie (1989:35-34) describes three main elements in the traditional model of science "typically presented in a chronological order of execution," namely, 'theory,' 'operation' and 'observation.' Babbie's (1989:35-39) view has some similarity with Atkinson, Atkinson and Hilgard's ('theory' includes observation of reality), as well as with Kalat's (formation of an hypothesis is part of this first step). For Babbie, 'operation', the step following the formation of a hypothesis, represents the design of a study to test the original theory, and in the third step—'observation'—the design is implemented. Here the meaning of the word 'observation' appears to include the naturalistic observation described by

Atkinson, Atkinson and Hilgard as well as the more structured observations that can be made through experiment, survey, case history or open ended interview. Babbie (1989:39) states that the formation of theory follows from "an interest in something or an idea about it." Again this is similar to Kalat's "casual observation." Thus although Atkinson, Atkinson and Hilgard describe a more rigorous first step for science, all three texts are essentially in agreement that a scientific project begins with some kind of picture of reality, drawn from casual observation, or from a more extended and meticulous study.

Before I continue with the discussion of the scientific process, it is important to consider the prior condition of a person setting out to conduct a study.
While none of the writers mentioned above discuss the possibility that the first picture of reality could be coloured by the experience as well as the assumptions or mind set of the person doing the describing, others have done so. For example, Rosaldo (1989:1-2) writes of his inability to absorb the possibility that rage can follow grief, and that the act of headhunting can act as catharsis for this rage: "...[for the Ilongot headhunter] grief, rage, and headhunting go together in a self-evident manner. Either you understand or you don't. And, in fact, for the longest time I simply did not". Until Rosaldo experienced the same emotions at the time of the sudden death of his wife, he was not able to 'see' what the Ilongot people were telling him. He writes (Rosaldo 1989:17):

> The ethnographer as a positioned subject, grasps certain human phenomena better than others. He or she occupies a position or structural location and observes with a particular angle of vision. Consider, for example, how age, gender, being an outsider, and association with a neo-colonial regime influence what the ethnographer learns. The notion of position also refers to how life experiences both enable and inhibit particular kinds of insight. In the case at hand, nothing in my own experience equipped me even to imagine the anger possible in bereavement until after Michelle Rosaldo's death in 1981.

Rosaldo has given an example of how a researcher is predisposed to see in a particular way. Kuhn (1969) describes 'normal science'—that is, the accepted theory and the accepted method—undergoing revolution when the weight of anomalies raise questions about their rightness. Kuhn does not challenge the traditional scientific model, he merely describes it, but in his book he illustrates how mind sets develop within traditional science. Rosaldo (1989) and Haraway (1988), arguing for the importance of situated knowledges to science, go further than Kuhn. Rosaldo (1989:21) echoes Haraway when he argues:

> The truth of objectivism—absolute, universal, and timeless—has lost its monopoly status. It now competes, on more equal terms, with the truths of case studies that are embedded in local contexts, shaped by local interests, and coloured by local perceptions. The agenda for social analysis has shifted

> to include not only eternal verities and lawlike generalisations but also political processes, social changes, and human differences. Such terms as objectivity, neutrality, and impartiality refer to subject positions once endowed with great institutional authority, but they are arguably neither more nor less valid than those of more engaged, yet equally perceptive, knowledgeable social actors.

Increasingly writers are arguing for the acknowledgment of situated knowledges, as well as for their representation in the social science literature. Certainly, the importance of the researcher's prior assumptions to the design and outcome of the study is increasingly admitted.

Now, to return to the traditional model. Babbie (1989:39) argues that the traditional model is based on the use of deductive logic, but he ends his illustration of the use of deductive logic, with an admission of deception (Babbie 1989:41). The study in question had begun not with a hypothesis as claimed, but with an interest in the topic. In order to reach a hypothesis about their original observations, Babbie and his co-researcher made a preliminary investigation using inductive logic. That is, the study is presented as though it began with a hypothesis, when in fact a qualitative study preceded the hypothesis. Nevertheless, Babbie's illustration highlights one of the features that distinguishes qualitative from quantitative research. As explained by Babbie, the line of thought within qualitative research tends to be inductive, with inferences made after the data has been gathered, whereas within quantitative research thought follows a deductive line of reasoning, with conclusions following logically from a comparison of data with an original hypothesis.

While quantitative research tends to be based on numbers, qualitative research tends to have words as its basic tool. Kirk and Miller (1986:9) state:

> Technically, a 'qualitative observation' identifies the presence or absence of something, in contrast to 'quantitative observation,' which involves measuring the degree to which some feature is present.
> ...'quality' connotes the nature, as opposed to the 'quantity,' or amount, of a thing.

Van Maanen (1983:12) makes the statement that although interpretive frameworks have become looser, more open-ended, fluid and contingent, they continue to give meaning to the data obtained through quantitative research. Qualitative research tends to be more interactive than quantitative research with researchers entering the world of those researched. The ideal goal of a qualitative research project is to record the view of reality held by those researched, to 'see' through the eyes of the other. The work of Rosaldo (1989) indicates how this can only be an ideal. It is never possible for one person to completely share the experience of another. This is especially so in a research situation when the social positions of researcher and

researchees are very different. However, ideal or not, to see through the eyes of those researched is a crucial goal of a quest for truth. It is a goal that might be attained when 'participants' or 'respondents' become co-researchers.

Often qualitative and quantitative research approaches are seen as mutually exclusive, but this is not always the case. Silverman (1985:17), for example, argues that they are complementary, and that one study can incorporate both. The goal within qualitative research is to establish a picture of the real world, while that within quantitative research is to establish the degree to which some phenomenon, event or relationship exists—hypotheses are formed and tested once a picture of reality is obtained. Qualitative research is a foundation on which quantitative research can build. Hypotheses or causal questions will be better informed if they arise from well established existing theory or from a well researched qualitative study rather than from casual observation. However, the boundaries between qualitative and quantitative research are not clear cut. A qualitative study becomes more quantitative as more instances of a particular behaviour are observed or more responses are gathered, and the relationship between the two is circular rather than linear (Babbie 1989:45). Inductive thinking involving generalisations drawn from observation leads to the development of theory from which hypotheses can be deduced. Hypotheses in turn lead to further observation. Both quantitative and qualitative studies are shaped by the assumptions of those designing and interpreting them, and they are usually used to investigate only one fragment of a large and complex system. Both are important in removing the distortions which occur. The picture gives meaning to the numbers; the numbers help to establish the accuracy of the picture.

The Rationale for a Qualitative Approach for this Study

My approach rests on a number of assumptions about social reality. Namely, that: social systems have the property of structure; social structures are composed of social groups, marked by relationships of power, and subject to varying degrees of change; and some groups and individuals are more marginal than others to the social mainstream. Systems of belief vary from group to group, and although a group can be seen to share a pattern of belief, individual members of any one group will have their own version of that system of belief. Since a social scientist has membership in a number of social groups, including that of a social scientist, she or he cannot work from a value free perspective. Systems of belief are in a state of constant change, which is brought about by a number of forces, including conflict arising from the individual variations of view within and between groups. Change can be imposed

from the people or person at the centre (at the top) or it can arise from the social margins.

To sum up, social reality is reflected in a composite picture projected from many different perspectives, and a social scientist works from at least one of these perspectives. Recently, a number of writers have argued that within social science the fashionable perspective has been called 'objective,' and that practitioners have idealised the experimental techniques of the physical sciences (Geertz 1983:21; Harding 1989:273-274; Oakley 1981:40; Sherif 1987:42). Haraway (1988:581) arguing for at least two views of 'objectivity,' writes of 'disembodied' scientific objectivity contrasting with feminist objectivity. The latter, she states (Haraway 1988:581), "means quite simply *situated knowledges.*" She continues (Haraway 1988:583):

> The moral is simple: only partial perspective promises objective vision. All Western cultural narratives about objectivity are allegories of the ideologies governing the relations of what we call mind and body, distance and responsibility. Feminist objectivity is about limited location and situated knowledge, not about transcendence and splitting of subject and object. It allows us to become answerable for what we learn how to see.

Haraway (1988:590) argues that partial views ('situated knowledges') can be joined into a "collective subject position," that they are not about isolated individuals but about communities, and that "the only way to find a larger vision is to be somewhere in particular."

A number of writers within sociology and anthropology have written about the conditional character of truth, and of the influence of mind-set on perceptions of reality (eg: Geertz 1973 and 1983; Haraway 1988; Rosaldo 1989; Silverman 1975). In Abercrombie's (1980:54) opinion, "The notion that every definable social location has at least the theoretical possibility of having a particular belief-system that is appropriate to it is the most important tenet of the conventional sociology of knowledge," and I have argued that a social scientist works from a particular perspective; a particular belief system. If this is so, research will be shaped and interpreted according to this perspective. The process of interpretation will involve placement of beliefs into the social context from which they have arisen and will be from the idiosyncratic perspective of the interpreter. Different writers have used different words for what I am calling 'perspective.' Smith (1987; 1990) uses the term "standpoint," Haraway (1988:587) describes "positioning" as "the key practice in organising knowledge," and Bruner (1986:129), writing about education, uses the word "stance," though he could well be writing about research:

> It must express a stance and must invite counter-stance and in the process leave place for reflection, for metacognition. It is this that permits one to

> reach higher ground, this process of objectifying in language or image what one has thought and then turning around on it and reconsidering it.

Haraway (1988:583) argues: "there is good reason to believe vision is better from below the brilliant space platforms of the powerful." From my life experience (see 'Introduction'), I know that there are many standpoints, but I find only one represented in most of the literature on the New Zealand health system. That is, the standpoint of the powerful, what Haraway calls the "the view from above." I want to record another—one from below, and one that has not been recorded before. Therefore, I am at the beginning of the scientific process, requiring some qualitative data. Once a picture begins to take shape, inferences can be made, hypotheses can be formed and consequently tested, but my main intention with this study is to record the standpoints of the people I interview. This study, then, is exploratory and descriptive—a prelude.

ETHICS

Reading a number of writers (including: Bryson 1979; Finch 1984 and 1986; Grundy and Weinstein 1974; Haraway 1988; Kidder 1981; Oakley 1981) has raised my level of awareness about ethical issues, and has shaped the research process that I have followed. Oakley (1981:40), suggests that the need of sociologists to be seen as scientific pushes them to model their discipline on physical science with an emphasis on measurement and 'objectivity.' Harding (1989:273-274) states:

> Only in the late seventeenth century was it first said that the positive benefit of science could be restricted to its method, thus making it unnecessary for scientists and the institution of science to be concerned overtly with the social, political and economic consequences of science.
> ...Scientific method is supposed to be powerful enough to eliminate any social biases that might find their way into scientific hypotheses because of the social identity of the scientist.

However, when 'method' is reserved for the data gathering exercise, questions of ethics can be reduced to how 'objectively' this is done. Validity, reliability, and representativeness of the sample group become elevated to the level of morality. The rights of the people participating are secondary to issues of 'objectivity.' Kidder (1981:373-401) offers ten categories of "questionable practices" in social science which represent violations of the rights of those researched. Haraway (1988:587) sees the struggles over what counts as a rational report on the world as struggles over how to see the world, and she emphasises the word 'how.' Bryson (1979)

argues that the scientific method is embedded in politics and ethics, and that it begins with the choice of topic. It ends with the way that results are presented.

In the following, I will trace the process I have followed in setting up this study, indicating what I saw as ethical concerns and what measures I took to resolve them. I will begin with my approach to the Massey University Human Ethics Committee and to the Ethics Committee of The Royal New Zealand Plunket Society, then I will write about my approaches to the nurses themselves, and finally I will write in more detail about the ethical issues related to this study.

The Ethics Committees

My submissions to the Massey University Human Ethics Committee and the Ethics Committee of The Royal New Zealand Plunket Society included a copy of my proposed consent form which outlined my intentions and the measures that I would take to protect the confidentiality of the information given by the interviewees. Both committees approved the study with further recommendations and provisos.

1) The Massey University Human Ethics Committee

My over-riding concern was for the well-being of those who chose to participate in this study. I wanted to ensure that they did not suffer as a result of their participation. In my work experience, I had found that there were negative repercussions for a nurse who spoke out. I had also found that in a small professional group similar to that of Plunket nurses, in a country with a population the size of New Zealand's it is difficult to maintain confidentiality. Distinctive voices tend to be recognised. In my application to the Massey University Human Ethics Committee I highlighted my concern and asked for advice. However, the Ethics Committee could not add any precautions other than those that I had already outlined, and one member of the Committee stressed emphatically the importance of 'spreading the net as widely as possible.' The Massey Committee also recommended that the length of the interviews be clearly and realistically conveyed, and that the sensitivity of the timing of the study be mentioned to the participants. At that time, the Plunket Society was facing restructuring, retrenchment and an uncertain future in the changing New Zealand Health System (Chapter 1).

The first concern was met by my approach to nurses working in a number of different areas in the North Island. Because of my concern, heightened by the Massey University Human Ethics Committee member, I will not divulge the name

or number of places that I visited in order to request participation from the nurses. Nor will I divulge the name or number of places in which the study eventually took place. I discussed the time commitment that would be expected of them with the nurses before they decided whether or not to participate in the interview. The length of the interview was also recorded on the consent form that each participant signed (Appendix 1). Among the people whom I approached within Plunket, only one saw timing as an issue. Most welcomed the study as timely.

2) The Royal New Zealand Plunket Society Ethics Committee

The Ethics Committee of The Royal New Zealand Plunket Society also approved the study subject to the provisos that: the consent form should include a statement about who I am, what degree I am working towards and what university I am associated with; point two on the consent form should include a statement to the effect that the tape or transcript would be returned to any nurse who decided to withdraw from the study; and that I give thought to the security measures I would take to protect the tapes and transcripts of the participants. The consent form (Appendix1) was modified accordingly and tapes and transcripts never left my home and were kept in a locked filing cabinet when not in use.

Ethical Issues

To end this section on ethics, I will use the principles from the code of ethical conduct produced by Massey University (1990:2) as a framework to outline in more detail the ethical issues connected with this study and the measures I took to resolve them.

1) Informed Consent

Informed consent relates to the stance of the researcher and the intentions the researcher has for the project, as well as to the content of the study. Before inviting Plunket nurses to participate in this research, I spoke to them about myself, giving some personal history, outlining my intent and the content of the questionnaire, indicating the time commitment that would be demanded from them and offering what I saw as the possible outcomes of the study. The consent form (Appendix 1) made explicit that the interview covered the participants' experiences as Plunket nurses and their views on the place of Plunket within the wider social context. When

I made phone contact with each nurse who volunteered to participate, I checked with her that she was indeed happy to participate.

2) Confidentiality

Except when nurses have themselves told others of their own participation, I am the only person with the knowledge of the identities of those who eventually participated. Only I have heard the taped recordings of the interviews or seen the transcriptions of them. Each nurse has been given a new non-identifying name. The nurses have seen the quotes that I am using and identifying material has been removed according to their wishes. Tapes and transcripts will be destroyed within three months of completion of the thesis. Further measures taken to protect confidentiality have been the geographic spread of the study together with deliberate vagueness about the geographical extent of the study and the particularity of the nurses concerned.

3) Minimising of Harm

As pointed out by the nurses themselves, a study can harm both a participant (or participants) as well as the organisation with which they are associated. It could also harm anyone mentioned in response to interview questions. I have written of my concern that arises from personal knowledge of the punitive nature of the social hierarchies within which nurses work.

Bryson (1979) argues that harm can arise at any stage of the research process, and thus my attempts to minimise harm began with my approach to the study and ended with my presentation of results, which went first to those who participated. After reading Bryson (1979) I wanted to avoid isolating Plunket nurses from their wider social context. As well, I wanted the nurses to think carefully about the implications of the research for them personally and for the Plunket Society. I resolved the first concern by extending the interview to include questions about social context and the latter concern by the way I approached the nurses and the contract that I set up with them. At the beginning of each interview, I said that it was important that the participant did not feel compelled to answer a question if she would rather not. During the interviews, if a participant appeared uncomfortable about answering a particular question I would suggest that we move to another. Measures listed under 'Informed Consent' and 'Confidentiality' also serve to minimise harm to the participants in this study and further measures are described under 'Social Sensitivity,' when I write about my relationship with them.

I have other concerns which are associated with the established method within social science. These concerns are shared by a number of writers, including those mentioned in the introductory paragraphs to this section of my thesis. The principle 'minimising of harm' is inadequate in that it focuses only on the negative. While practicing as a public health nurse I had observed people living on the breadline agreeing to participate in research in the belief that the result would be an improvement in their circumstances: "If people learn what life is like for us, something will have to be done about it." Since that time the situation of these people has deteriorated. Too often the only people who gained were the researchers. Therefore I aimed to design a study which would give something back to participants (for details, see 'Social Sensitivity' below). My commitment to this aim was reinforced by my reading of Bryson's (1979) paper.

4) Truthfulness

There was no necessity for deception of any kind in this study. My intent was to record the standpoints of Plunket nurses. During the interviews, if participants queried what I wanted from them I stressed that what I wanted was their point of view. In presenting the thesis, my intent is to be as true to their statements and to their emphases as I can.

5) Social Sensitivity

The words 'social sensitivity' can be applied to awareness, tolerance and sensitivity of social differences at the level of the group as well as at the level of the individual. I will begin with the latter.

The principle, 'minimising harm,' reveals an awareness that research can have an adverse effect on those who are researched. As Bryson (1979) demonstrates in her paper, 'social sensitivity' can take this awareness into a more actively positive mode. I began this research with the intent that Plunket nurses would have some benefit from their participation in it. I hoped that the questions I asked would give them a chance to reflect on their work, helping them to gain distance and new perspectives on it. I hoped that the research would provide a channel to allow their voices to be heard. The process I followed was similar to that outlined by Freire (1972), increasing the probability that both the nurses and myself would learn from it. The process also complied with Haraway's (1988:592) view:

> Situated knowledges require that the object of knowledge be pictured as an actor and agent, not as a screen or a ground or a resource, never finally a

> slave to the master that closes off the dialectic in his unique agency and his authorship of 'objective knowledge.'

Respect for the people researched is implicit in the above quote. In working towards reciprocity in my relationship with the people whom I interviewed, I hoped to avoid the 'conventional' relationship described by Oakley (1981:40):

> Interviewers (typically) define the role of interviewees as subordinates; extracting information is more to be valued than yielding it; the convention of interviewer-interviewee hierarchy is a rationalisation of inequality; what is good for interviewers is not necessarily good for interviewees.

Both interviewer and interviewee become dehumanised in this process, but the interviewer holds the superior position, and abuse of rights as outlined by Kidder (1981:373-401) can occur more readily. Grundy and Weinstein (1974:49-54) note the double morality that can occur in this kind of situation. Cultural sensitivity is critical here.

The relationship which an interviewer sets up with an interviewee reflects a closeness (or otherwise) to the moral principles (such as trust, respect, truth), which pertain to all human relationships (see Chapter 1). The meaning of the word 'subject' as it is used in philosophy—'that which thinks or feels as opposed to the object of thinking and feeling'—is often inverted in the social sciences and in medicine, to become 'a person or thing that undergoes experiment, treatment' (Makins 1992:1340). From a philosophical perspective, a person who is a subject in the social sciences is in fact an object. When people become objects it is illogical to treat them as equals, and to present them with the results of the research in which they have participated. Through the research process those who are its focus can be disempowered.

The people whom I interviewed are culturally similar to myself: Pakeha, female and with a background in nursing. I felt a rapport with these people which I think was mutual. They spoke freely, and were deeply moved, as I was, by what the questions brought to the surface for them. Added to this, the interviews occurred either at the place of work or at the home of each participant. That is, they occurred on the territory of the participants. Social sensitivity is a necessary prerequisite to entering and conducting a successful interview in the territory of another.

Sensitivity about the current social position of a particular group or of a person from a particular group is a further aspect of social sensitivity. One member of the Massey University Human Ethics Committee demonstrated this when he queried the timing of the study (previously mentioned). As already discussed, the vulnerability of a nurse within a hierarchical system was also uppermost in my mind throughout the research process.

This study is an investigation within Pakeha culture. All actors within it, including all of those whom I contacted within The Royal New Zealand Plunket Society, were Pakeha. However, the effectiveness of an organisation, such as the Plunket Society, is partly dependent on the relationship it has with other cultural groups. This is has been shown in studies in which support was found for Hart's Inverse Care Law (see Chapter 1). Therefore, in this research, one of my interests was to investigate this relationship.

Investigative Procedure

In designing this study, I have drawn from Yin (1984) and McCracken (1988), as well as from a range of other writers. My experience, in both the public and the private worlds, has also informed this thesis. From design to analysis of results, I have drawn from my commonsense knowledge of what it is to be a woman and a nurse practicing in a New Zealand setting. Furthermore, my personal history is very similar to that of the majority of people who chose to participate in this study. I was born in 1941, trained as a nurse in a public hospital, and then married and reared two children. Because shift-work suited the hours that child rearing demanded my main paid occupation has been hospital nursing. My long- standing desire to work as a public health nurse was not realised until my children were older and more self-sufficient. My main difference to the people whom I interviewed is that I spent three years teaching in a comprehensive nursing programme in a polytechnic and I am currently a full-time university student.

It could be argued that my familiarity with the experience as community nurse and mother would be a cause of bias, but I have found it to be of great assistance in approaching a number of people within the Plunket organisation, including the nurses, and in understanding what it is that they have said to me. Silverman (1985:173) maintains that "to understand what is displayed in interview accounts we are forced to mobilise our commonsense knowledge." Oakley, (1981:58) an experienced interviewer, sees personal involvement as "the condition under which people come to know each other and to admit each other into their lives." Salisbury (1992:25) concludes that "the closer an interview can come to an in-depth conversation the more full and rich one can expect the resulting information to be." The ability of interviewer and interviewee to understand each other reflects on the quality of the data gathered.

Approaching The Nurses Themselves

When I first approached the nurses I uncovered strong reservations which echoed with my own experience. In order to progress, it was essential to address these reservations. Therefore, the study began quite intensively with the nurses themselves. Because of what it reveals about them and their social context, I will trace in some detail the process I followed. In this section, the more punitive aspects of the culture in which nurses work become more apparent giving some indication of why nurses might be reluctant to participate in a study such as this and why I, as a nurse and as a researcher, feel so protective of those who did take the leap.

On the 26th September 1991, I approached a principal Plunket nurse about the feasibility of doing the present study. She advised me that The Royal New Zealand Plunket Society would consider my application to do this research more favourably if I could say that Plunket nurses were willing to act as participants. Therefore, in order to determine how Plunket nurses would feel about such participation, I addressed two groups of nurses at their respective weekly staff meetings. At both meetings some nurses expressed strong resistance.

Resistance centred around three issues:

- *time*
  These were busy people, some of whom had already participated in research which had taken considerably more of their time than had been negotiated.

- *the study might be unhelpful to the Plunket nursing service*
  Other studies (eg: Salmond, 1975) were perceived by some of the nurses in this way.

- *the possibility of negative repercussions for those who chose to participate*
  Nurses were anxious about outcomes for them personally. This anxiety was increased by their knowledge of what happened to a nurse who 'spoke out.' Just prior to my initial contact with Plunket nurses, a hospital nurse had been threatened with dismissal by her employer—the Auckland Area Health Board (see, 'Nurse warned over critical editorial,' The Dominion, 8 October 1991)—for writing an editorial in The Listener (O'Connor, 1991). This nurse suffered repercussions from her employer even though her comments in the editorial were restricted to consideration of the effects of Government policy and did not implicate the local Area Health Board in any way. When I approached Plunket nurses about this study, they mentioned this incident.

  Historically, nurses have been silenced. This was evident in the investigation into the cervical cancer study at National Women's Hospital in Auckland. Coney

(1988:239-240), while reporting on this study, analyses the position of nurses. From my own experience, Coney's description of the place of nurses at National Women's is the same as the place of nurses working in other public hospitals, in private hospitals, within the Department of Health and more recently within Area Health Boards. Coney (1988:240) writes:

> Stephanie Breen, for the Nurses' Union talked about the power structure in hospitals and how this affected nurses: 'The hospital structure has a culture all of its own. It is very hierarchical. At the bottom of that power structure, there are the nurses...Nurses are powerless in this situation.'

Summing up the situation at National Women's Hospital, Coney (1988:241) wrote that the hierarchies and boundaries of power were maintained with everybody knowing their place. 'No one stepped out of line.' In the course of the inquiry, Michael Churchhouse (a cytologist), when asked if he had considered going to the medical superintendent of the hospital with his concerns about the cervical cancer research, replied "If you understood the hierarchical system that operates in a hospital...you probably would see that that would never even cross my mind" (Coney, 1988:240). Within this system a nurse holds less status and less power than a cytologist. A nurse who refuses to be coerced into this system is subject to discipline.

My response to the issues raised by these nurses was:

- to be clear about the amount of time the study would involve for each nurse,
- to be clear about the measures I would take to protect the identity of each nurse,
- to list what I saw as the possible outcomes for those who chose to participate and for the Plunket nursing service as a whole.

Several nurses volunteered to participate from each of these initial two groups. After I obtained approval from The Royal New Zealand Plunket Society, I continued to follow the same process, contacting principal nurses and asking if I could speak at staff meetings to tell Plunket nurses about the proposed study and to invite their participation. Some nurses were eager to be part of the study, others wanted to participate but continued to express concern about outcomes, while others were adamant in their refusal to take part. By Christmas 1991, the study was approved by both the Massey University Human Ethics Committee and by The Royal New Zealand Plunket Society, and the number of nurses wishing to participate was sufficient to continue.

Interviews began at the end of February 1992. Over the next two months I interviewed twelve nurses who worked in different parts of the North Island. All worked in urban areas—some in provincial towns and others in different parts of a metropolitan area. In terms of personal histories, most were more alike than they were different, and (as indicated earlier) in many respects my own biography is similar to theirs. Nine of the nurses interviewed were born between 1933 and 1947, were married with children who were adult or nearly adult. These nurses had received their basic nursing education in a hospital programme. A very small minority were under thirty years of age with no dependent children. The majority had worked as a Plunket nurse for more than five years and a few had also worked as Plunket volunteers for a number of years. Only a small minority had worked outside of nursing for more than a year. However, regardless of difference in age and life experience the attitudes of these nurses turned out to be more alike than different.

Because of the nurses' concerns, because of my own concerns and because of the previously mentioned concerns of a member of the Massey University Human Ethics Committee (who also had considerable inside experience of the New Zealand health system), I have not been specific about the nurses and the areas in which the study occurred. I wish to do my utmost to protect the identities of these nurses unless they state otherwise. This lack of detail will detract from the richness of the study, but I believe the research is still of considerable worth. These nurses are in agreement with each other, and their responses are consistent throughout each interview and across interviews. This consistency of response serves to further protect the identity of those who participated in the study, since the majority of statements could have been made by any one of them.

Questionnaires and Interviewing

In order to gather background details, I asked participants to complete a short pen and paper questionnaire (Appendix 3). However, the most direct way to discover the standpoint of a particular group of people is to ask them. Therefore, my main instrument of investigation has been a tape recorded long interview. McCracken (1988:9) writes:

> The long interview is one of the most powerful methods in the qualitative armory. For certain descriptive and analytic purposes, no instrument of inquiry is more revealing. The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the lifeworld of the individual, to see the content and pattern of daily experience. The long interview gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves.

Drawing from my own experience I developed a set of open-ended questions (Appendix 2) probing the areas of: the New Zealand health system; The Royal New Zealand Plunket Society; the nurses own education (formal and informal); their motivation in becoming Plunket nurses and their views on career; their views on relationship; what it is they see as supporting them and constraining them in their work; and their experience of change.

As mentioned earlier, my aim was to establish and maintain an egalitarian relationship with those participating. Each interview was arranged by telephone at a time and place convenient to the nurse concerned. All interviews were conducted over the period 28 February to 29 April 1992, and occurred in the place of work or the home of the nurse concerned. Most began with a cup of tea or coffee while I set up the tape recorder and while the written questionnaire was filled in. I usually took some food with me.

I tried to adopt a style of interviewing consistent with that proposed by Finch (1984) and especially Oakley (1981:41):

> . . . when a feminist interviews women: (1) use of prescribed interviewing practice is morally indefensible; (2) general and irreconcilable contradictions at the heart of the textbook paradigm are exposed; and (3) it becomes clear that, in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship.

At the beginning of each interview, I asked the nurse concerned not to answer a question if she would rather not, and if a nurse appeared uncomfortable during the interview I did not press for a response, but asked whether or not she wished to continue. The interview questions were open-ended, allowing the other person to answer as they wished. I did not interrupt when a nurse did not answer a question directly, but assumed that the question had elicited something of importance that was uppermost in that person's mind. At times, when a participant came to a halt, I either reflected back to her what she had been saying, or I continued with the questioning, sometimes using a prompt, sometimes continuing with the next question in the interview. I re-introduced a question if it had not been addressed at all. Even so, not all participants answered to the point of every question.

Data Analysis

Analysis began as each nurse talked to me and it continued as I transcribed the tapes. It seemed to me that I had collected a large number of words—on average,

twenty-seven pages per nurse. By transcribing the tapes myself I became more familiar with the themes in these pages and with the nurses themselves. Also, transcribing spoken word to written word brought home to me how much information speech carries—tone of voice, laughter, emphasis—and how much of it is lost in the writing. Even so, as I listened to the nurses, and as I transcribed what they had said from tape to paper, I was struck by the consistency and similarity of response. The interview questions tended to be repetitive, and each nurse maintained her initial response throughout. More surprising to me was that on major issues these nurses were in complete agreement with each other.

Again, the similarity of my socio-cultural background to that of the people I interviewed was helpful. I found that I could draw on this common ground in making an analysis. McCracken (1988:11-12), argues:

> It is precisely because the qualitative researchers are working in their own culture that they can make the long interview do such powerful work. It is by drawing on their understanding of how they themselves see and experience the world that they can supplement and interpret the data they generate in the long interview.

But he also warns, "Just as plainly, however, this acquaintance with one's own culture can create as much blindness as insight." During the interviews, I checked frequently with participants that I was understanding **their** meanings, and sometimes I found that my own assumptions were leading me astray. As I analysed the nurses responses, these times of misunderstanding resurfaced in memory as islands of disjuncture in interviews which were otherwise memorable for their degree of rapport. As I analysed the data, it was as though I had each nurse looking over my shoulder assisting me in my attempt to 'get it right.'

In the chapters that are based on the transcriptions, I include a large number of quotations from the nurses. These quotes are somewhat streamlined. For example, I omit words (such as 'you know') which recur but which do not add to the meaning. This makes the quotations easier to read and the characteristic speech patterns of a particular nurse are removed, further protecting her identity, but information is lost. However, the messages that the nurses gave are conveyed, and since most of these messages are in agreement a strong collective voice is established.

In analysing the data, my aim was to draw out the major themes in order to build a picture of the standpoints of these nurses. I assumed that they spoke the truth as they saw it. That is, I did not see them as attempting to respond in socially acceptable ways, or as lying. A long interview will only work if those interviewed feel respected, trusted and protected. Silverman (1985:171) responds to the possibility that "interviewees are not fully moral or not intellectually up to scratch" with the following:

> We need not hear interview responses simply as true or false *reports* on reality. Instead we can treat such responses as *displays* of perspectives and moral forms. This need to preserve and understand the reality of the interview account is central to the argument of interactionists like Hammersley and Atkinson about the importance of accounts as 'evidence of particular groups' (Hammersley and Atkinson 1983:106). However, it also arises in some otherwise positivist arguments, as in Brown and Sime's claim that 'An account is neither naive nor an apology for behaviour, but must be taken as an informed statement by the person whose experiences are under investigation' (Brown and Sime 1981:160). Finally such a position is intrinsic to Garfinkel's (1967) argument that accounts are part of the world they describe.

That is not to say that Plunket nurses are not subject to denial (in the Freudian sense), or that they do not have a distorted vision. They see what they are able to see from their particular place and their view from that place is valid, but the view from any particular place is only the view from **that** place. As more studies seek to establish the different standpoints represented in each social system a mosaic reflecting the complexity of that system will be established and distortions will become apparent.

Other Sources of Data

Because the major focus of this study is the standpoints of Plunket nurses, I have tended not to use other sources of data. During the course of the study I have followed and kept relevant newspaper and magazine articles, which has helped me to keep up-to-date with the status of Plunket nurses, but I have used very little of this material in this study. This is also the case with official documents from The Royal New Zealand Plunket Society. Silverman (1985:173) suggests:

> ...The leap from an ethnography of a tribe to the analysis of interview data is not as great as it looks...the analyst should seek to establish the cognitive universe or cosmology being displayed; no additional pieces of information are needed, only the elements present and the way they combine.

Validity and Generalisability

Recently, I have participated in two surveys which were part of extensive, expensive research projects. As I filled in the form for each I felt constrained by the shape of the questionnaire. Had I restricted myself to ticking in the boxes as required, my responses would not have reflected my views. An observational study, or the responses to an open-ended questionnaire, can lead to a more accurate picture of reality than research which is more narrowly focused. I agree with Salisbury (1992:32), when she writes:

> In analysing peoples' stories it seems appropriate to move the emphasis from technical issues of reliability and validity (ie. the investigator's problems) onto respondent's problems in constructing coherent stories to make sense of their experiences. When one can allow this natural process to occur as unimpeded as possible, then the results will be meaningful data about peoples' experiences.

Smith (1987:107) advocates a sociology which retains the voices of all who participate in it. Her aim is to write sociology texts which retain the presence of people interviewed as knowers and actors; that is, as 'subjects' in the modern philosophical sense of the word (Makins 1992:1340), while at the same time exploring and explicating the context of relations in which people live their everyday lives. She indicates how descriptions of the detail of the everyday world can contain within them descriptions of social relations which are not specific to that particular setting, but which pertain to a variety of settings (Smith 1987:157):

> The particularising description gives access to that which is not particular since it is embedded in categories whose meaning reaches into the complex of social relations our inquiry would explicate. Ordinary descriptions, ordinary talk, trail along with them as a property of the meaning of their terms, the extended social relations they name as phenomena.
>
> Thus taking the everyday world as problematic does not confine us to particular description of local settings without possibility of generalisation.

Smith describes this approach as overcoming the criticism that extrapolations cannot be made from particular descriptions arrived at through interpretivist methods. She asserts that by beginning with the everyday world as problematic the problem of generalisation is by-passed. Each person is viewed as holding some knowledge of the properties of social organisation, and therefore, "The particular 'case' is not particular in the aspects that are of concern to the inquirer" (Smith 1987:157).

Reliability

The social world is always changing, therefore I would not expect a future study of Plunket nurses, even the same Plunket nurses, to be identical with the current thesis. Further than that, given the idiosyncrasy of researcher perspectives, I would not expect another researcher to produce an identical interpretation of the responses I have reviewed. Just as the surveys in which I recently participated were shaped by the assumptions of those designing them, so this research has been shaped by my assumptions. However, I attempted to avoid restricting respondents by these assumptions by using open-ended questions, by focusing on their responses and by prompting them to explore further these responses. Even so, I could not avoid influencing how a particular person might respond. Body language, the way in which

the questions were framed, and participants' perception of my nursing background as a source of commonality in values and attitudes and experience would do this.

CONCLUSION

I began this chapter with the suggestion that quantitative and qualitative research approaches are complementary. Qualitative research can be used to reveal the nature of a phenomenon while quantitative research can be used to measure the degree to which it is present. Since I aim to describe the standpoints of Plunket nurses, a qualitative approach is most appropriate for this study.

I found that of the number of ethical issues related to this study, two were of particular concern to me. The first of these, was that the people who were interviewed could gain from their participation, and consequently all questions invited reflection on action. My second concern was to minimise harm to these people, and therefore much of this chapter relates to the measures I have taken to protect participants. As part of this protection, I have not given individual descriptions of the nurses who took part in the study. Instead I have described a little of their social context as nurses and I have offered a broad outline of them as a group. They will continue to introduce themselves in the following chapters, when I present what it is they have said. As I listened to them, and as I transcribed and analysed what they said, I found that they were more alike than they were different; that each could be described as having a shared rather than an individual standpoint. This standpoint acts as a representation of their world views at the time that they were interviewed. Hence, it is an informed statement about that world, but it is also part of that world. It is, in Silverman's (1985:173) terms, a 'display of reality.'

The nurses who participated in this study selected themselves. After I spoke to each group of Plunket nurses I invited them to comment and to participate. In each instance a minority volunteered. Therefore, the Plunket nurses who participated are probably not representative of all Plunket nurses. Given the current social conditions of The Royal New Zealand Plunket Society, of nursing generally, of the health care system and of Government support for social services, it is conceivable that they are a select group. Given the social conditions, it would take courage and resolution for a Plunket nurse to participate in this study. It is may be that the nurses who did take this step are representative of those nurses who are in the vanguard of change that is occurring throughout nursing. This possibility is supported by the nurses' responses, which consistently reveal a group of people who actively participate in change.

Regardless of how representative the group of nurses who responded to this study are, their responses stand as a legitimate representation of their views.

My main intention was to chart part of the territory of social reality from the perspectives of twelve Plunket nurses. I wanted to make a beginning; to make an observation; to produce something that others can (if they wish): refute from their own standpoints, draw on to support their own theories, and/or build new theories. But my primary goal was to be as true to the nurses as I possibly could.

Part Two: The Nurses

CHAPTER 3

MOTIVATION, PERSONAL GOALS AND CAREER CHOICES

In the introductory chapter, and drawing from my own experience, I wrote of the different worlds that people inhabit. Bernard (eg: 1972; 1987) has produced a whole body of academic literature on the different realities within the one household, and Schaef (1981:147-159), discussing the very different attitudes that people can hold on a particular issue, constructs a framework she calls 'levels of truth.' Haraway's (1988) paper offered some explanation of the phenomena of constructs and theories within social science presented as reality. I have previously mentioned ('Introduction' and Chapter 2) that viewpoints presented as fact in the academic world do not always fit with my own view of reality. This was first impressed upon me when as an undergraduate student in the 1970s, I was taught that the need to achieve was worthier and healthier than the need to affiliate. Further than that I was left with the impression that men had a high level of motivation to achieve with a lower level of motivation to affiliate, that the converse was true for women, and therefore, that women were inferior. That this view was accepted doctrine was supported by Broverman et al (1970:1), who found in surveying the attitudes of clinicians that "characteristics judged healthy for an adult, sex unspecified, which are presumed to reflect an ideal standard of health, will resemble behaviours judged healthy for men." In the eyes of the clinicians, who participated in that study, it would be impossible for a woman to be both a healthy woman and a healthy adult. Schaef's (1981:147-159) idea of different levels of truth helped me to understand both what I was experiencing in the real world(s) and the difficulties I was experiencing with the literature. Haraway's (1988) paper offered further explanation of the phenomenon of constructs and theories within the social sciences presented as reality.

When I looked up 'career' in a lay dictionary (Makins 1992:200) I found definitions similar to my own: 'a path through life'; 'a profession or occupation chosen as one's life work.' There is, in these definitions, intimations of continuity and growth throughout life. But 'career' is also seen as an ascending ladder within paid employment. To use a second metaphor, each job is seen as a building block within a career. This latter view appears in the literature. Delamont (1980:100) uses the term 'career-building,' and Rosenfeld (1992:40) reviewing recent literature offers 'a sequence of jobs' as a definition of 'career.' Rosenfeld does add that 'career' has 'overtones of some sort of progress or at least coherence to the jobs a person holds over the work life.' Although Rosenfeld uses the word 'life,' the implication is that 'career'

refers only to that part of life which is remunerated in cash, whereas all of life is central in the lay dictionary definition.

I asked the nurses for their ideas about 'career' because this word appears to represent one of those issues around which there are different levels of truth. In this way, ideas about 'career' were similar to ideas about 'need to achieve' and 'need to affiliate.' The questions that I asked the Plunket nurses arose out of the dislocation between my own orientation towards 'motivation' and 'career' and that presented in many academic works. I wondered what sort of picture Plunket nurses might present. Accordingly, this chapter begins with responses concerning the motivation to become a Plunket nurse, and is followed by sections on responses to questions on personal goals and nursing as a career.

MOTIVATION

What motivated you to become a Plunket nurse?

When the nurses talked about why they became Plunket nurses, a tangle of reasons emerged. However, both the concept and the reality of 'family' appeared as highly valued. For example, Fay talked about always wanting to be a Plunket nurse: "But," she said, "it had to be at the appropriate time. I had to wait until my children were independent before I could do it." All of the nurses, who had children of their own, expressed the same concern and commitment to their own families. Hope said:

> There's life beyond Plunket. I try and remind myself of that. I feel it (Plunket) consumes me too much. If I had to choose between home and my family and Plunket nursing, I guess Plunket nursing would end. It has to be family first.

Robyn gave a fairly detailed history that showed that whether she worked in unpaid or paid employment depended on what she saw as her commitments at home at that time. Family commitments came before paid employment for these women, but family commitments were also combined with voluntary work. Wendy and Susan, like Robyn, had worked as Plunket volunteers for many years prior to becoming Plunket nurses.

Kate, among those who talked of a personal enjoyment of children, took the Plunket course as a young woman because of this interest, and she too did not work as a Plunket nurse until after she had some experience of rearing her own children. As a young woman, Kate had seen herself as "too inexperienced in life" to work well as a Plunket nurse, but her interest in and commitment to children had stayed with her over the

years.[1] Love of children emerged as a strong motivating factor. Mary emphasised this as a reason for her working as a Plunket nurse. She said of children: "I believe in them." Fay, also talked of her love of children:

> When I had my children I enjoyed (them). I do enjoy families...I've always enjoyed children and when I was a kid...I used to do a lot of baby-sitting. I always wanted to be a child nurse...Not with sick children; that's really distressing to me.

Working with sick children in hospital can be extremely distressing. There are high levels of anguish associated with caring for people who are sick, especially people who are very young and very sick. Mary, like several of the others, had been working in a paediatric ward, and she said, "I needed to get out of the hospital and do something health related rather than illness [related]." The nurses were unanimous in linking their love of children to their desire to prevent children becoming sick. Those who had worked in public hospital paediatric wards found that this experience fired their ambition to prevent rather than to cure. This was so for Susan, who talked about the same children re-admitted again and again with illnesses that were preventable. She wanted to work in a way that would help to keep children healthy. Mary said, "It would be better to do health education than to have children coming in sick with what could be prevented."

Kate, who had always been drawn towards Plunket work because of her love of children, found that, when at last she became a Plunket nurse she had a close affinity with other mothers: "It is the mothers that I really and truly do enjoy." Such an affinity was acknowledged by many of the nurses in the course of the interviews.

Beth had reservations about becoming part of the Plunket organisation. She saw it as demanding a great deal of support from the people who used Plunket services; that is from Plunket volunteers—people who already had very demanding jobs at home. She said, " I was very, very reluctant to become a Plunket nurse [but] I am really committed to preventative health because I think that's really where to start... It was really a good friend who said to me, 'I think that would be a good job for you'." Beth came to Plunket because of a strong commitment to prevention; a commitment which over-ruled her misgivings about the structure of The Royal New Zealand Plunket Society.

A positive role model also appeared as a motivating factor. Noreen wanted to work as a Plunket nurse because her own Plunket nurse had inspired her: "She's a great person...an ideal role model, she liked the job...I wanted to be [a Plunket nurse] for a long time until I actually got the courage to [do something about it]." Wendy was amongst those who mentioned family history when I asked her "Why Plunket?" Her

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[1] This awareness of self-limitations and personal monitoring of performance, implicit in what Kate said about herself, was a feature of the interviews. It has a direct relationship to the concept of safe practice—a concern which continued to be expressed throughout the interviews.

response also indicated a tangle of reasons similar to those of the other nurses. Like the others, this tangle included a partiality for children and a concern for one's own children at home:

> Well, two of my aunts were Plunket nurses, and a younger sister, and my mother's sister next to her. I think basically I'm interested in kids. I really like little people. I think the shift work worried me too when I was doing night duty in nursing because I felt there was a lot of time that I wasn't home with the children and it was quite nice to get back into a 9.00AM-4.30PM job.

Apart from her family history and her interest in children, Wendy had had a long involvement with Plunket, having used the service and worked as a volunteer within it for as long as ten years before joining its paid workforce as a nurse.

Plunket nurses are expected to attend meetings in the evenings, but otherwise, unlike many other nurses, they do not work shifts. Even so, Wendy was the only nurse to mention the regular hours of Plunket nursing as an incentive to work for Plunket. Only one nurse (Hope) mentioned money when asked directly about what motivated her to be a Plunket nurse. She did not elaborate on this and I did not question her, or any of the other nurses, directly about the need for income. I assumed that by asking an open question, nurses would talk about those needs that were of most importance to them. It should be noted however, that Plunket nurses are not well paid. If these people were looking for a highly paid job within nursing, they would be looking outside of Plunket if other work were available.

When she was discussing Plunket nursing as 'career,' Lynn introduced the topic of money:

> I have to be honest. Like most other women my age, with kids at the stage that they're at, I do need the money and there's not a lot else offering in nursing. And the options I see; I don't know whether I like them apart from midwifery. (Plunket) is one option that (I knew) I would really enjoy .

Lynn's salary helped to supplement the family income, but she stressed that for her the satisfaction inherent in this kind of work was more important than the money . The pattern that emerged was one of women putting their families first, and as their children became more independent feeling more free to move into paid employment. This move coincided with the added financial pressure of older children requiring increasingly expensive education.

Lynn and Hope talked about a move to another town and about loneliness. Hope said, "We'd just moved here from a little community and I found it very difficult to get into a group. I enjoy people and I found it very difficult to fit."

As well as looking for ways to meet other people, Hope was searching for ways to help children. She talked about the pain of losing a child who had been part of her family for a long time:

> The other thing was we had been fostering a lot. We had one child for years, and the system as it was, returned him back to his mother...I felt that I could go so far with helping somebody and then it was completely taken away from me. I felt like I wanted to be able to do more and make it count more...There was the idea of Plunket being able to (do this). So that's what made me go into Plunket.

In this way, Hope presented working as a Plunket nurse as a way of contributing to the health of children with more security and more certainty than she had had as a foster parent.

Working as a Plunket nurse arose out of a time of transition in one nurse's life. As she talked about the crisis in her working life, she expressed what a lot of nurses feel as they confront the culture within a hospital:

> I was facing a lot of major decisions and I knew that I could have gone further within the hospital system if I had really done all the right things and said all the right things to the right people. I just couldn't bear it. I would have loved to have worked in a charge nurse capacity but I just felt that the ways and means of getting there—I just couldn't stand it...It would have meant compromise rather than just being accepted and recognised on your own merits. I also knew ...that in order to do that, I really had to start making inroads into a nursing degree and I just wasn't ready to do that.

A temporary Plunket nurse position was advertised, and she thought, "Oh that sounds really different. It would be a hoot if I got it." Once she made the transition from hospital nurse to Plunket nurse she found that in many ways she was able to work as an independent nurse practitioner. She said:

> It offered a lot of the things that I hadn't realised I wanted from nursing. It offered independence, but a sense of accountability. It offered working with the individual which I have always enjoyed, but affecting a wider sphere in terms of family and community. I found that I really enjoyed children which was a surprise, so that was a bonus. It offered working with women, which I've always enjoyed, and it was to do with education and empowerment which, although the hospital was meant to be doing those things it often wasn't happening. I could see that in community health you really had the opportunity to do that. So I guess those are the things that motivated me.

This last quote acts as a partial summary of what many of the other nurses have said. Plunket nursing was seen in terms of opportunity. It offered an opportunity to meet other people, to make a financial contribution to one's own family and to work more independently than most nurses. But most importantly, it offered an opportunity to prevent sickness and misery by presenting a setting for nursing that was aimed at improving the health of children, relationships within families, and general feelings of well-being.

Caring for others was the major theme underlying the nurses' motivations for their activities within both their public and their private lives. This motivation (to care for others) was accompanied by an equally strong need to see people move towards health,

and it seems that this latter need drove these nurses towards self improvement; towards the development of their own potency—a major theme within the nurses responses when they were asked about their personal goals.

PERSONAL GOALS

What are your personal goals as a Plunket nurse?

When I asked nurses if they had any goals for themselves, all talked about doing something for others. In this context, most talked about their work, describing what they hoped to achieve. These aspirations corresponded with their ideas about the value of the Plunket nursing service and their goals when working with families. For example, Trish said, "I want to help a mother and baby have a good relationship...and to help them to achieve what they want in their relationship, and to see that the children themselves get a fair go." Summaries of similar responses are recorded in Chapters 6 and 7. Robyn, giving a slightly different response, mentioned maintaining a positive image for the Plunket Society. A positive image for Plunket was highlighted also by Wendy, who said, she would like other health workers, "...to see the role that Plunket nurses are fulfilling in the community and be aware that we are a non-threatening organisation; that we are there to help mothers with young babies and families."

Two nurses were concerned about their responsibility towards other Plunket nurses, not in the sense of improving the Plunket image, but in terms of personal support. Both of these nurses were senior Plunket nurses, and they talked about creating the best possible environment for the nurses with whom they worked and for whom they carried some responsibility:

> One goal would be to be able to support (Plunket) nurses, to be there to provide supervision. To spend an hour—two hours—to get rid of everything that's on top for them... I think that the Society has been very poor at recognising (this need). I get very angry when I see and hear about the supervision that social workers have. I believe that the work that we do is very similar; has the same stresses. ... The other (goal) is...to have two Plunket nurses working together, as well as Karitane nurses, in a family centre, where you could support each other and use each other's skills. I think it would work really well . I don't think it will ever happen, but that's what I'd really like to do.

Those who did begin with themselves were intent on facing what they saw as their shortcomings in order to seek further education to improve their expertise. As with monitoring one's performance, knowing one's own limitations is closely related to safe practice. The ultimate aim of these nurses was to be able to offer a more effective service. Noreen talked about trying to re-motivate herself and how important it was for

her to remain interested in her work—"otherwise you just go downhill and never come back up again." Others, taking counselling courses, talked about improving their understanding and skills. Kate's aim was to be able to really hear people—to know where they stood—so that any advice that she gave was in tune with their lives and orientation, rather than with her own outside position. Listening—the first step in counselling—is essential in learning to see how others see their situation and needs, a major requirement for people wishing to by helpful to others. The idea of safe practice was implicit in what Kate said:

> Even though we are referring on, it's us people come to, and sometimes they won't go any further. But you can't be all things. I think what a person in this position needs are counselling skills. I've learnt a lot of them on the way, but I still know my limitations and I do refer people to the experts.

Several nurses, to improve their over-all knowledge, were taking courses towards a diploma in social studies. Fay was one of these:

> Social studies really works in with what I'm doing. It's something that I decided that I wanted to do. Not because they'd asked me to do it. It's not something that Plunket Society says, "This is what you should be doing," but I could see that it would be useful in helping me. And it is, and the Plunket Society recognises this too, because they give me study leave which I think is great.

Beth, taking similar courses to Fay, talked about further education for herself, and then said, "so my personal goals are to help people as much as I can."

These nurses appeared to be highly altruistic people[2]. When asked about personal goals they talked about supporting others. They went beyond the education offered by the Plunket Society, seeking what they saw they needed to help them improve their practice. Fay made the observation that she saw further study as "absolutely essential." She said that she appreciated its importance more now because she could see the benefits from the courses she was taking. She said, "You can't just sit there and do your job, you have to continue to study." In order to develop their capabilities as nurses, these people were taking courses that extended themselves as people.

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[2] In this use of "altruistic," I mean an "unselfish concern for the welfare of others" (Makins 1992:36).

CAREER

A Personal Career

Do you see yourself as having a career?

When she heard this question, Hope echoed several of the others: "This is a tricky one isn't it? Where did you find these questions?" Because the word 'career' holds different meanings for different people, this question caused some confusion. Susan reacted to this question by saying: "Professional level, titles, money...that's how a lot of people see career, and that to me is not important." I asked her if there was another way of seeing 'career,' and she reiterated, "Oh yes, I see myself as having a career...but the general opinion is ...that it is ladders, hierarchy, money, status...How much you bring home is your worth in this civilisation." It seemed that Susan felt that she had to assert her view in the face of opposing views, and that she did this by stating what she saw as 'general opinion,' and then saying that that was not her opinion. Other nurses seemed uncertain about themselves in relation to having a career. For example, Robyn said, "Well I've had a career now. I've been back another ten years. I presume it's a career." Both Noreen and Hope, on the other hand, gave an unequivocal, positive "Yes," they had a career.

When I probed to get some idea of how these people defined 'career,' Noreen emphasised that it was important to her not to work set hours but to end her day with her work in a satisfactory state of completion. She talked about "total commitment to the job in hand." Kate said, "Yes...nursing is a career. There's no doubt about that. It sort of envelopes you doesn't it?" Beth thought it through as she talked:

> The word 'career' needs to be re-defined, because if (you have) a job do you have a career? If a teacher has a career, then I have a career. Yes I think I have a career...If you have a factory job, you might not see yourself as having a career because your goals are decided for you. Career is something we see as being more involved.

For Noreen, Kate and Beth a career is something which involves investment of the self. Their idea of 'career' seems to be closer to the idea of 'life work' than to 'work life.' Beth continued with her comparison of 'career' and 'job':

> A career also means that you have to continually up-date your information base, and when you are in a factory you don't really have to do that. But to me a career person is a person who keeps herself really up to date and adds to her knowledge base all the time. It doesn't have to come from the employer. It comes from the person herself. You may have a very different idea, but I think I have a career.

Like Beth, Wendy also saw 'career' in terms of "an expanding of knowledge." Others talked about self-motivation and self-regulation as necessary conditions to 'career.'

In terms of the 'ladder' idea of 'career' all of these nurses were at the bottom, or close to it. This can be a dilemma for any nurse who wishes to continue to practice as a nurse, when the career ladder leads away from nursing practice and into administration. Mary used the words "clinical pathway" to describe a career at practice level:

> I need to get into special areas and have a clinical pathway. My goals, career -wise in Plunket, would be to become more competent and good, very good....When I felt I had accomplished that, then I'd look at going into another area . I do think I have a career in nursing.

The rewards, for a nurse who remains a nurse in the present system, must be intrinsic. There are few extrinsic rewards, such as promotion, and positive feedback is not always forthcoming. Hope said, "Well it would be nice to be recognised for extra things that you do...It would be good to know that all your work has been worth something." A career, following a clinical pathway, could include recognition of developing proficiency. Mary commented: "I think that somewhere along the line there should be recognition that you [have acquired more effective skills]. Whereas you're a nurse and that's that. I'd do it anyway without recognition, but it would be nice to get it."

One of the participants, who had just left the Plunket nursing service in order to care for her first child, had a sense of 'career' which reflected the lay dictionary definitions:

> Now that I am no longer working in paid employment... I look upon motherhood and the things that I'm doing with my child and within my family as something really positive, and really important, which if you want to put it in terms of 'career,' yes, it is at the moment.

Fay's sense of her Plunket work as 'career' was similar:

> This is what I want to do. This is what I'd like to end the rest of my working time doing. I don't want to do anything else. I would like to continue working with families in the community, whether it's Plunket or whether it's something else. If I can continue to improve on what I am doing and help in this area, that's what I want to do.

Both of the last quotes are congruent with the definition of 'career' as 'pathway through life' or 'life work.' In many ways, 'career' for these nurses was similar to 'vocation,' that is in the sense of a 'special urge or predisposition to a particular calling or career' (Makins 1992:1511). Their view of 'career' was in conflict with the reality within Plunket, which led into administration and offered a 'ladder' of promotion to a very few nurses.

Career Structure within Plunket

What are your thoughts on the career structure within Plunket?

The structural changes that were occurring within The Royal New Zealand Plunket Society became highly relevant to these interviews when I began asking about career. I talked to some nurses immediately following an announcement that principal and senior nurse positions were to be discontinued and that there was to be a re-ordering of area boundaries. What career structure there was, was to radically change. When I asked about the career structure within Plunket, many replies were like Philippa's. "There isn't one really. You either decide you just want to be a Plunket nurse or you [go into] the administration side of things." Lynn, whose initial response was immediate—"Goes too much into administration"—elaborated: "I do see myself as having a career. I really enjoy being with families. I enjoy the work that I do. I don't enjoy the Plunket system. It's undergoing change. I'll wait and see what happens down the track."

There was a limited hierarchical career structure for nurses within Plunket, which Beth described. "You can go from district Plunket nurse and then you can become a senior nurse and then principal, but there are so few positions at that level." Other nurses knew very little about their career structure. Some weren't interested. "That's a terrible question," Fay said, "To tell you the truth I don't know too much about it...I mean I'm out there doing what I want to do." Another said that the career structure had never been explained to her. "You're not told that you can work up a ladder [or that] there's merit awards." Seeking clarification I asked whether Plunket nurses got merit awards: "Apparently we do, but nobody ever gets them." She continued to talk about seeking a merit award, not for herself, but for another nurse. Her story revealed the difficulty of a principal nurse constrained by a system with a very limited budget:

> She (the nurse) deserves a merit award. She's the back-bone of the place...and I wanted to do something for her to show that I appreciated her. I went to the Principal Nurse who said "Oh I can't do that. If I have to give one to her I'll have to give one to this one and that one."

Switching to her own situation, she said that she was often asked to talk to groups outside of her normal working hours:

> ...So I don't think much of their system at all. I know at the moment I'm asked to do this that and the next thing for different people all over the place...At the moment I've got four different things waiting for me to do. And I keep saying "Why should I do them?" "What do I see for it? Nothing." I don't get any more pay, I don't get any more hours to prepare anything in. Nothing like that. So I want to question why that happens. I'm not a bit impressed with the career structure.

I think it is of consequence that this nurse could ask for recognition for another nurse, yet not for herself. Much of what was said in these interviews suggested that these Plunket nurses were experiencing the powerlessness that is common to nurses working in other settings. Yet they have the courage to act as advocates for others.

I asked Kate, who had had a position of responsibility and status within a public hospital before she married, if the career ladder within Plunket was one that she would wish to follow. She replied:

> Not now, no. I must say I'm not all that ambitious now ... If I was a younger person and had not had such a big family, perhaps yes. But no I wouldn't want to be up at the top really. I want to be where the people are whom you serve. ... I guess I had those skills, but its funny when you get married and have children. I guess for a long time I thought I'd never get back to nursing. I had so many little children...But no, not at this time. I wouldn't want to mainly because of my commitments (at home).

This statement of Kate's revealed some ambivalence. Kate recognised that she had administration skills, but she also found working "where the people are whom you serve" immensely rewarding.

Wendy was the other nurse who would do it differently now:

> Well I would probably be fairly ambitious, given the opportunity again... I would be aiming for a masters degree or a Ph.D...I come from a family of medical people and most of them have moved onwards and upwards. I wouldn't want to stay as a field worker all my life, but saying that, I really enjoy what I am doing and I don't regret that I haven't gone on.

Wendy's statement echoes that of Kate. Even though these two recognised their own potential as managers, both enjoyed their field work. Their attitudes towards their work followed the same patterns as the other nurses. Wendy said, "I am here because I wanted to be here. I chose Plunket because that was the area of nursing that I really wanted to get involved in." Both Kate and Wendy arranged their working lives around the needs of their families, as had all of the nurses with children of their own. Wendy, should she have 'advanced' up the ladder, would have taken her caring approach with her: "I wouldn't be thinking about status or money. I'd be thinking about becoming more lateral and more knowledgeable and [being] able to offer more to people."

Wendy began to address the dilemma faced by nurses of 'promotion' out of nursing practice into administration in association with further education:

> I think that it's the same with any profession that you take on, if you want to keep your interest and extend yourself and your knowledge you've got to be prepared to go on and do the papers...They were talking about Plunket nursing becoming a university degree. I don't know if that will ever happen and I don't know if that is the best thing... I feel that the people who probably give the best service are the people who continue on and do further papers, like breast feeding papers and human development papers and maybe even now some nutrition papers but ... I think I'd be careful that people who work on the ground level like Plunket nurses don't get too qualified too, because that's what's happening in the

> hospital system. There's all these highly qualified administrators and nobody to give out the bedpans. We don't want to get into that sort of thing.

This is an ongoing dilemma for nurses; whether to try to ascend the power hierarchy or whether to continue to remain relatively powerless and unrewarded in a monetary sense, but continue to practise as a nurse. Most of the nurses I interviewed expressed dissatisfaction with the career structure within the Plunket Society. They wanted to remain nurses and not to become administrators. Philippa said that she was never interested in promotion within the Plunket hierarchy: "I felt I would lose the things that drew me to the job in the first place." Mary, who was interested in staying with nursing practice, said "I don't think there is really a career structure in Plunket. Going up the hierarchy gets you away from nursing. [This] doesn't interest me...I wouldn't like that, but I think that's true of a lot of areas of nursing." Wendy, when she talked about nurses not taking higher degrees, was talking about what many of these nurses saw as important. That is, a career pathway which involves recognition of developing nursing skills, abilities and effectiveness.

By taking a number of wide-ranging courses nurses can develop their practice capabilities. But there is a lack of avenues to use these developing skills. Lynn recognised that this was so within Plunket: "There is very little opportunity, in fact there is no real opportunity, for nurses at this point to look at areas they would like to specialise and develop specific skills in."

SUMMARY AND DISCUSSION

All of the nurses participating in this study talked about a career structure approximating the dictionary definitions quoted above ('a path through life'; a profession or occupation chosen as one's life work), whereas in the literature the concept 'career' is presented in terms of building blocks within paid employment. A more popular metaphor presents 'career' as a ladder with each ascending rung offering more status, more money, more responsibility, and more power over more people. I suspect that the confusion, the ambivalence and the defensiveness discernible when most of the nurses talked about 'career' stems form their perception of this latter view as the dominant one within Pakeha culture, and they disagree with it. Susan articulated this very clearly. A career ladder is the norm within the biomedical system. It also characterises the established career structure for nurses within The Royal New Zealand Plunket Society. Nearly all of the nurses voiced their dislike of this career structure. The minority, who said they would be open to promotion to administrative positions if they were just beginning a nursing career, made it clear that they enjoyed the work they were

doing, and should they have become administrators, their work would have been based on the same principles as their current nursing practice. They found Plunket nursing satisfying in itself.

As these nurses talked about their motivations and about their personal goals, their paid work could be seen as an extension of their unpaid work. They were motivated to help others to live as fully as possible, to attain something like Katherine Mansfield's ideal of health (Chapter 1). Their own family at home was their first commitment, but as their children became more independent these women extended their work to other families. For one of them the process was reversed and she switched from working full-time as a Plunket nurse to working full-time as a mother.

To attain their expressed goal of helping others requires a high level of self awareness, self monitoring and up-dating of knowledge. It requires as well a reaching out to means of resolving inadequacies in personal practice. Self awareness was demonstrated by many of these nurses, in their reluctance not to become Plunket nurses until they felt they had the required intuitive skills (Lumby 1993a:6). Their search for knowledge and skills in courses outside the Plunket organisation demonstrated both self awareness and an ability to take the initiative to resolve recognised personal inadequacies.

These women would appreciate recognition and support for the work that they do. They would appreciate a career pathway at practice level. Even so, I have described them as altruistic. I can think of no other word that sums them up quite so well. That they thought first of others was most apparent when I asked them about their personal goals and they talked about what they wanted to do in order to be more effective in their work. In very broad terms, their main concern was the public good, but in order to achieve this goal they have to shape themselves to be as effective as possible. Although this shaping involved self-enrichment in the form of additional study in a number of different disciplines, their ultimate aim was to be as effective as possible in helping others to realise an optimum state of health.

CHAPTER 4

EDUCATION: LEARNING TO BE A PLUNKET NURSE

Education systems for nurses are problematic. Reid (1965) and Carpenter (1971) critiqued the hospital based programmes in New Zealand, and Perry's (1985) study included a reflective critique of the polytechnic programme. Broadly, Reid and Carpenter found the hospital based programmes to be narrowly defined and inflexible. Carpenter (1971:23) recommended: "Hospital-orientated training programmes should give way to more broadly-based health-orientated education. The curriculum should provide for study in the humanities, biological sciences, with nursing related throughout." The transfer of nursing education from the hospitals to polytechnics followed this report, and recommendations made by Carpenter became a reality. However, Perry (1985:85) found that there were forces, within both the polytechnic departments of nursing and the hospitals, which acted to constrain graduate nurses to comply with 'established nursing culture'; that is, as Lumby (1993b:4) described it, to become "identified with obedience, selflessness, virtue and hard work as well as rigidity of approach." These reports reflected my own experience, and raised questions about education for nurses.

When I came to interview Plunket nurses I found myself wondering what was useful for them from their formal education, their paid work experience and their private life experience. My intent was to investigate the sources of knowledge that Plunket nurses use in their daily working lives. The chapter therefore begins with a section on learning from private life experiences. This is followed by a summary of comments made about the basic general nursing programme and the introductory Plunket course. The chapter finishes with a section on suggestions for the basic Plunket course.

LEARNING FROM LIFE

Is there anything from your own personal background that helps you do your work?

This question proved pivotal in this part of the interview. It set the scene for who and what the nurses are and for what became apparent as their desired mode of practice as they talked about their goals when working with families, and their views on ideal relationships. All of the nurses emphasised the importance, to their practice, of the knowledge they had gained from their experience outside of formal educational

institutions. And they saw this knowledge as being derived from a wide variety of sources. When I first mentioned education, Kate said, "I think age and life experience has been most helpful to me."

Work Experience Outside of Nursing

The few who had worked for more that a year outside of nursing transferred learning from these experiences to their nursing practice. Lynn talked about work, other than nursing, which had brought her into contact with a great many people. In order to do this work she had had to learn to be effective in her working relationships. Similarly, Beth described her experience as a playcentre supervisor as invaluable in terms of learning relevant to her Plunket work.

Travel and Contact with a Diversity of People

Robyn valued learning to become comfortable with social difference which she had gained from travelling. Kate also put herself in a global setting when she talked about her learning, and Fay described the international composition of her own extended family and indicated how this, together with extensive world-wide travelling, had helped her to develop tolerance and understanding of others. She said:

> I feel that I don't have expectations of people, I wait to find out who they are. I find that that's really helpful. I didn't think like that when I was young, single and not married. Working in the hospital when I graduated, I thought I knew it all and nobody could teach me very much. That's changed and it still keeps changing. Life experiences help me a lot in understanding people and differences, which is good. It's really good.

Family

Learning tolerance and learning how it feels to be experiencing a particular event emerged as important sub-themes as the nurses talked about their experience of family at home. For example, Beth and Kate stressed the significance of their childhood experience of their families of origin. Kate, talked about learning acceptance of others as well as learning a positive parenting style from her own mother, while Beth said she appreciated values she had gained as a child:

> If people were wanting help they would come to my mother. She had a real gift in that way. So I grew up in an environment where health was very important. Health was talked about. So I can see that that is the reason why Plunket is important to me because health has always been so important to me. When you experience this as a young person it becomes a part of you...

One nurse, who spent months at a time as sole 'head of family,' talked of the independence and resourcefulness that she brought to her work because of this experience. Likewise, the experience of living in a three generational family was seen as assisting the development of tolerance for others. All of the nurses who had children of their own commented on the understanding, tolerance and sense of perspective that that experience had brought them. Wendy said:

> I think that has been the biggest help to me, in that I can relate to how people are feeling and to what is normal development. If you've had children and you have learnt that there is such a wide variance of normal, it can be very reassuring. You might see somebody who looks quite slow and yet you know jolly well that you had one of those yourself and he turned out to be perfectly all right.

Many nurses saw learning how it **feels** to be a parent as having primary importance. Lynn was one of those who indicated how her experience within her own family contributed to her practice as a Plunket nurse.

> Certainly having children is the major thing. And also ...learning that relationships fluctuate, that maybe things that aren't going well in one area will often come right. The biggest thing for me with children is the fact that one of ours didn't sleep. He would be awake from one to two every night for about a year. That has given me incredible experience in working and dealing with mothers with sleepless children. I can recall wanting to do horrible things and being so angry towards him the following day because he had kept me awake all night. It was terrible. It has helped working with mothers—giving them a sleep programme ...and the satisfaction when mothers ring up and say it's wonderful —being able to understand how the parents feel. It's such a relief for them to be able to talk about it.

Susan also drew from her experience as a mother:

> I draw a lot from my own experiences and I don't just mean...physically, I mean mentally. How I felt after having a child. How I felt when I had four screaming babies. I learnt a lot from that...I think that gives me a better chance to feel inside other women. On the surface they put on a bright face. On the surface they seem to be coping, but often they're not, and I know that feeling and I can often twig to it. Unfortunately probably not as much as I should be doing, but I think that is the most valuable experience: being depressed with children and eventually climbing out of it...It has really created insights into other people (for me).

Similarly, Hope, talking about her experience of motherhood, said that sometimes you just get bogged down and can't see your way out. She talked about living in an isolated situation remote from extended family, and then of the reassurance, when in this situation, of hearing someone say, "Well I experienced that...and it will pass." She said, "I know what it feels like to have no-one to call on. I use that [knowledge] a lot in my work."

Mary, one of the nurses who had had no direct involvement in child-rearing, presented something of a contrast. Mary detected some criticism from colleagues. She said, "I haven't had children... I appreciate that having had children would help, but I

think that [when you don't have children of your own] people doubt that you can perceive what the situation would be like." Mary felt this censure so strongly that it proved extremely distressing for her. When I asked if there was anything from her private life which she used in her practice, she said:

> I remember distinctly going to Plunket and being made to poke my tongue out so she could look down my throat. We weren't allowed to poke our tongues out, and (I remember) Mum being very cross with me because I wouldn't co-operate. (Now) I will not force a child to do something they don't wish to do. If they will not do it I'm not going to stress them out. Yes, that definitely has affected my practice. I also remember my father said to me when I was young...he said , "Children are not chattels. They are little people and they have rights." ...(Parents) have a right to mould and to guide, but not to ruin someone else's self esteem. That's how I view children. Not as rational and complete little adults, but they have rights.

As Mary continued to talk, it became clear that she had learnt a great deal from her family of origin:

> Also...having older parents and an older brother and sisters—watching them in their lives does affect your experience and perceptions I don't know how to pin it down: family peace and struggles, relationship doubts and rough times, mortgages, financial insecurity and good times, the wonders of the first words, first steps, first smiles...I've shared these experiences. They've influenced who I am and what I think. I'm not made of stone. I'm capable of perception. I'm offended with the attitude "you can't possibly understand. You don't have children." That attitude hurts very deeply.

Mary, like the others, transferred learning gained from her own family life experience to her nursing practice. Some of this learning involved understanding how it feels to be in a particular situation, how it feels to be treated in a particular way. It is not always easy to pin down when and where particular learning occurs, or what it is that is learnt from a particular configuration of events. But there is no doubt that for these nurses their private lives had proved to be a rich resource from which they could draw to enhance the quality of their practice. The tolerance, understanding and respect that they had learnt from their families, helped them to put themselves in the place of others. These qualities or principles proved to be the basis of their practice (Chapter 7), and they represent a kind of knowledge that is very difficult to teach in a formal educational setting.

Service Users

Nurses also talked of learning from the families using their services. Kate, after mentioning that the Plunket course gave her insight into where she had gone wrong as a parent, said, "The Plunket nurse, whom I took over from when I first came back [to nursing], said she'd done most of her learning from the mothers. I often think how wise she was, because that's where I've done my learning." I suggested that that was a

humbling thought and she continued, "Yes it is, and even now, I add up my children's ages [about 180 years], and I think gosh I've had all these years of parenting and I find there are still things to learn." Fay was another who talked about learning from those using Plunket nursing services:

> ... from families. I learn a lot from them. I have to because their ways are different from mine. And so it's a blending. When I can see something that is useful...if I can see it as better than my way, or what I've been taught, I will use it. So there's a lot of just life experiences that you use. When it (Plunket training) was all over and I started doing my Plunket work, I didn't find it was really wonderful at all. I didn't find that it was that helpful...We as Plunket nurses need to learn a lot culturally, but that develops because you are working with people from different ethnic groups. I've learnt a lot from the people, not from books.

Learning from parents—parents of all creeds and races—emerged as a dominant theme when I asked the nurses about their ideas on ideal relationships with those who were using their services (Chapter 7). Providing they saw it as helpful, these nurses were open to acquiring new information regardless of the quarter from which it came. That this was so, placed them as working within Ferguson's (1982) new paradigm for health practitioners. For these people the whole world was the classroom. All situations were seen as educational, anyone could be teacher and learning was life-long. As well as tolerance, understanding and respect, to be so open to learning requires humility. It was Noreen who said, "I'm still learning. We're all learning all the time and I don't think we'll ever stop." She spoke for everyone.

Formal Nursing Education

As a nurse and as a Plunket nurse you have received formal education and training. Thinking back on this education and training what has been most helpful to you?

To what extent has your work experience contributed to your work effectiveness?

When asked about their formal education as nurses, responses become more equivocal. These questions were difficult to answer. Hope's response was typical: "Hospital training? I wouldn't know how much of that I use, but I do use it." Philippa, one of the youngest people interviewed, was one of the closest in time to the formal professional education she had received, and she said:

> From the actual training itself you could almost say nothing, because you are picking up things all the time and it's hard to pin-point when you pick them up...It's too long ago in some ways to think what my training taught me. All I could say is that I have learnt; that each little part of nursing that I have experienced has taught me something new .

The suggestion, that we assimilate new learning with the knowledge we already have, and that it is not always easy to remember how, when or where we acquired it, underlies what Philippa has said. Beth, using the metaphor of trying to pick up one thread out of a piece of fabric, said, "It's assimilated. It becomes [part of] your understanding of people and [part of] your empathy [for them]."

Learning from Theory

However, while the nurses were engaged in the difficult task of sorting out one thread of learning from all the others in an intricately woven tapestry of knowledge, some common themes began to emerge. Philippa talked about learning organisational skills within the hospital where she trained. Other nurses said that from their general education as nurses they were using knowledge about anatomy and physiology, about drug effects, about illness and treatment. Noreen spoke favourably, but in general terms, of both her general and her Plunket courses. All emphasised the importance of practical work experience.

Learning from Practical Experience

When they talked about both their basic general training and their Plunket courses, the nurses tended to talk about practical experience rather than theory. It seemed that the lessons of experience stayed in their memory longer than information given in the classroom. Thus, Robyn drew from her prior experience as a public health nurse, while Hope said, "I'm always thinking back to experiences in the wards. Especially the paediatric ward." Mary likewise talked of the sound knowledge of childhood illness that she had gained working in a children's ward. She added, "Practical work experience...my knowledge base is mostly from this experience." Lynn talked about learning whilst working in out-patient clinics. This knowledge now enabled her to indicate to parents the processes they could expect to occur given a particular medical problem within their family. She also learnt about the feelings of parents from working in obstetrics:

> ...the whole joy of it...The look on the parents' face...That prepares you and allows you to really listen to parents who are besotted with their kids. But also the other extreme, those mothers who have incredibly difficult deliveries—allowing them the opportunity to express their feelings ... and being able to understand (that not everyone feels attached to their infant.)

Similarly, Trish and Kate talked about the practical skills that they had learnt whilst working in Karitane Hospitals; skills which they were now able to teach to parents. As the nurses talked, the ease of learning from experience, and thus the importance of juxtaposing experience and theory, emerged as a major theme in their responses.

Juxtaposing Theory with Practice

The suggestion that the ease of understanding and remembering new information increases as accumulated knowledge increases underpinned much of what the nurses said. It seemed that new knowledge is more easily assimilated when there is closely related knowledge already contained in memory. When there is not a foundation of experience—a well established landscape of consciousness—the convergence of theory with practice becomes crucial. Beth talked enthusiastically about in-service education, which had related closely to her current practice:

> We had a paediatrician come once a month to give us a lecture and I feel very fortunate that I had that experience, because she educated us up to a level that we can really be proud of...She would prepare a lecture that any medical student would benefit from, even our general practitioners, and we had a basis where we could ask questions. Often she asked us what topics (we wanted)—any particular thing that was prevalent—whooping cough or outbreak of something else. She would go over it...All that has been cut now. If we have a question we can ask the paediatrician who covers the whole Wellington area, but it's not the same...We have had many excellent speakers, We have often been allowed to make choices for ourselves...I wouldn't like to work in a job where there was not in-service training. I think it is very valuable (to) keep up with what's going on...We get a lot of reading material, but it is hard to keep up. Having it (reviewed) by a specialist we would know what was important...It was a great help.

Beth has described the ideal. When I was teaching in a Polytechnic programme, I found that it was not always possible to arrange theory to coincide with practice—one aim of such a programme—and I could remember how much I had learnt from practical experience as I completed a hospital-based programme. One polytech prepared nurse said she gained knowledge and confidence from practice **after** she had registered.

However, there are ways of introducing learning from experience into the classroom. From what was said, it seems that anecdote can act as a stand in for experience. Of her basic nursing education at polytech one participant said that she remembered some of it. I asked her if she meant information, and she replied, "No, not so much that. It's more the anecdotes. The stories that people told you of their experiences. They came alive." She gave the example of a tutor's story about driving past a house, and washing, which was always on the line by 9.00AM, was not there at 11.00AM:

> She knew something was really wrong and that she had to go back there. At the time, as a young teenager, I thought, "This is beyond me." But (those anecdotes) ...stuck in my mind . When I started working for Plunket they'd jump into my mind, especially when I knew myself that something was wrong because that house didn't usually look like that at that time of the day—"Oh! That's what she was talking about!"

She added that the comprehensive programme for nurses needed to be different. "I don't know how you do it, given that you can only teach people who are willing to learn, and you can't give someone life experience." Motivation emerged as an important factor in learning, yet learning is also possible for those who are relatively unmotivated. The same nurse continued: "I think teaching community health is a really hard thing to do. The more I've thought about how to teach it, the more I've admired the tutors we had who did so well. Especially with a bunch of teenagers who weren't really interested."

Introductory Plunket courses included time out with practising Plunket nurses, and many nurses mentioned this experience as the most helpful part of their Plunket education. Beth had been out with two different Plunket nurses as part of her basic Plunket course, and said that when she was faced with working on her own this experience was "absolutely, vitally important" to her. When asked what was most helpful for her from the Plunket course, Hope said, "A lot of the practical—going out with another Plunket nurse was very good." Wendy elaborated on this:

> The thing that helped me most (was going out) with different Plunket nurses and trying to pick out from them who had the best skills. I thought, " I really like the way that that person handles her clients and that's how I'd like to be able to cope."

Fay's experience highlights the importance of a positive role model; of seeing the work of another nurse whose practice is effective. Unfortunately, the course that Fay attended placed students with only one practising Plunket nurse. She said:

> ...(going) out with a Plunket nurse. I see that as a very valuable part of my training. I was put out with a Plunket nurse and I ...was really angry, and I'm **still** really angry , very, very angry, because that was one of the big areas that didn't teach me a thing. If I'd been out with someone who had been a good Plunket nurse, a motivated, in touch and up to date Plunket nurse, I wouldn't have been nearly as nervous as I was when I went out there (on my own). I would have been looking at it with different eyes.

Hope provided another example when she talked about the confusion aroused by observing the work of a nurse who was telling her that what was taught in class was an unrealistic ideal and that the real world was not like that. She talked also of the fatigue experienced by practising Plunket nurses:

> I went out with some nurses who were just exhausted. One nurse in particular. I went back to the tutor and said I don't want to go out with her again because I

> don't want to be a Plunket nurse if that's what it's all about, and she put me out with somebody else.

That learning derived from experience is better fixed in memory than theory presented in class underlies much of what was said. Lynn, who received her basic education in a small general hospital, made a response which was more concise than the others but which typified what they said. She mentioned theory first, switched quickly to learning from experience and ended by talking about how one enhanced the other. What Lynn said serves both as an illustration of the importance the nurses placed on the combination of practice and theory and as a summary of what they said:

> General training—that's really going back—I suppose basic anatomy and physiology . I did a lot of night duty in the children's ward, and specific experiences like nursing a child with diphtheria has left me with an awareness of the importance of immunisation. I guess I really learnt the most in the wards, but you needed the (theory) to understand what you were doing. They did coincide—fitted in together. A small hospital is really great, because with one surgical ward you have the lot. You have accidents, gynaecological, men's prostates, appendixes, terminal cancer. You had them together in one ward. That in itself is incredible. I didn't realise it at the time, but I have since...When I think back it was incredibly stimulating for me that as you were learning theories you were actually practicing it. (You had) an opportunity to practice a range of things all at the same time...(Theory) and practice did tend to coincide and that was a positive aspect of training in a small hospital.

Learning from lived experience was highly valued by the nurses in this study, and they learnt from experience in a multitude of situations. The current polytechnic comprehensive programme and the Plunket nurse programme incorporate both practice and theory modules, but the nurses accounts suggest that the juxtaposition of theory and practice could be improved to facilitate learning. When this is not possible a substitute for experience can be introduced into the classroom. The use of anecdotes emerged as one example. Adapting a course to a student's level of learning also emerged as important in the nurses' responses.

The Match between Course and Learner

Several nurses talked about incongruence between a student's level of knowledge and a courses' level of orientation. One nurse who had gained her basic nurse education within a polytechnic programme sounded surprised when I asked her about formal learning:

> I must have been there, but I don't remember the teaching that we got. I know I learn practically by doing. I remember a few times in my training I'd been in the ward, and then gone to class, and it was like, "Oh!" The lights were on. It all made sense. But often it was more an academic learning of these things...Theoretically

> polytech matches your learning with your experience but it doesn't always work out to plan.

Then I asked her how older women in her class managed. She said:

> They did do really well. I couldn't believe these women—there were about 7 or 8 ...in our class —who had children...who said I'm going to have a second go at this, and they just went, and they learnt everything. I was of the mentality that you learn what you had to—the minimum, and then you picked the rest up on the job ...I was very impressed with them, but I couldn't do it.

It seemed that at least one polytechnic programme discriminated against younger students who had not had the life experience to effectively assimilate course material readily, and who were perhaps not as strongly motivated as older students.

Some Plunket courses were seen by the nurses as discriminating against women who had not studied for some time. According to Wendy:

> Some of the assignments that we did were...marked by tutors from a university. Their expectations of the nurses were very high and their marking was very unfair...The people who had done university papers before... and knew what was expected got good marks, and the poor old things who hadn't done anything like that were given Es, but that didn't mean that their knowledge was any less than ours. It was just that they didn't know how to present it.

Fay illustrated further what Wendy was talking about:

> I found it (the Plunket course) very interesting, very hard work because I hadn't done any study for a long time... I just had to learn to study again. You do get right out of it. You don't realise how far out of it. We had an enormous amount of child development... I could do it now and would find it easy. I would find it really enjoyable, but it wasn't then. It was really very, very difficult and I was really worried. I was really scared ,and I thought "God I've got to be able to recognise what children should be able to do at these ages. I've got to recognise deviations. I've got to recognise that there's delays (in development). I've got to recognise all these things. I don't think I can do it." Yes, it was awful. I thought "I've got to go out there and I've got to take a clinic and that child mightn't be doing right and what do I do? Do I refer, and look like a twit because there is nothing wrong with (the child)? What do I do?"
> ...When I started as a Plunket nurse I didn't find that (the Plunket course) very useful at all. It should have been, but it was too hard. It was just too much for me. It was all too much. So I found I was using my own experiences. I think that that's what a lot of Plunket nurses do.

Kate said that she was able to assimilate knowledge from the Plunket course that she attended because she had had the experience of raising children; of being up all night, coping with sick children. She found that the course she was given was appropriate to her experience. She was ready for it. The same was true for Wendy, whose experiential learning was reinforced and expanded by theory:

> (Plunket training) reinforced what I had learnt in my general and maternity training, and then working, and then having a family. So that what we were taught (in the Plunket course) reinforced what I had already learnt and made me realise that there were wide variations, and that what was happening in the

> community that I lived in happened in every other community, and was in most places very acceptable.

Philippa, too, was ready for the Plunket course. Typically, she spoke of the practical aspects of the course first when asked what was useful about it:

> I think obviously all the practical things...Dealing with children in a wellness orientated setting, because it is just so totally different from sick children. I really enjoyed the developmental side of things because it was something that wasn't gone into in a great deal of depth during my training. I got a lot from...sociology and psychology and that sort of thing... I guess for me it was a time when I consolidated a lot of the things I had been thinking about nursing, but just hadn't sat down and put into so many words. So it was both a training for me in the area of child and maternal health, also a time of seeing myself in the nursing field and where I fitted in and what I thought about that.

Philippa was also ready to practice independently of others working in the same agency as herself. She began with some history:

> I worked in a (general medical) practice that did not give me a lot of nurse autonomy. He (the General Practitioner) didn't really believe in practice nurses that much. That was incredibly hard, but in retrospect it was good for me because it made me think: "What are nurses worth? Is the way this man treats nurses the way we should be treated...or is he really missing the point? I did a lot of thinking about nursing because of that, which meant that by the time I was ready to do the Plunket course I was really keen to be independent...that wasn't a rejection of the medical model, but just feeling more comfortable with the way you can practice within the Plunket structure as a nurse.

Although it was not the case for everyone, for Philippa, the Plunket course was ideal.

Plunket nurses educate each other, when they attend courses together. Since they are intimately acquainted with the problems that each face they are able to offer each other useful information. Peer support was a recurring theme throughout the interviews. The value placed on support received from other nurses, was evocative of my own experience as a public health nurse. Given the isolation that a nurse working on her own can experience, peer support, as Wendy pointed out, is an important aspect of any work related course. "One of the things that is really good in any [Plunket] course is the fellowship...Years later you've still got that same relationship with those people, because you've been with them for four months. You know them really well." Philippa, highlighting the peer support aspect of Plunket courses, identified the added bonus of being within a group characterised by shared understanding. "I enjoyed the fact that we were supposedly mature students who had really varied backgrounds and had a lot to offer one another from nursing...I felt that just by rubbing shoulders with one another, both as nurses and people, we taught each other a lot."

Responses reflected a wide variation in readiness in those taking formal courses in nursing education. Courses did not always match the student's level of readiness. Apparently, these courses required some flexibility in order to meet the differing needs

of the people taking them. When asked about possible additions to formal courses, most responses were addressed to the Plunket course. These will be considered in the following section.

PROPOSITIONS FOR THE BASIC PLUNKET COURSE

Is there anything in particular that you would like to see added to this education and training?

The Royal New Zealand Plunket Society has offered a 17 week post-graduate course for nurses as preparation for Plunket nurse work, as the need for staff has arisen. A wide range of topics is covered in the curriculum with both theory and supervised clinical practice included. From the responses of the women participating in this study it seems that the emphasis within each course has varied according to the priorities and views of the people organising and teaching it. Also the curriculum has varied over time according to the changing needs of families and changing theories. Added to the variation in emphasis in each course as it has been presented, each nurse came to the course with her own personal variation of readiness to learn. Therefore the recommendations made by the nurses, and recorded below, might have been met in some situations but not in others. However, many of the following suggestions have general application.

The importance of other Plunket nurses as role models was emphasised. Fay, who because of her own experience (previously mentioned) had concerns about the clinical component of the course, was adamant that Plunket nurse students should be placed only with highly motivated Plunket nurses. "I do know some Plunket nurses out there who are brilliant, and if you are training they are the people who you should be with."

That the Plunket course should set realistic expectations on would-be Plunket nurses was also stressed. The nurses emphasised the need for the Plunket course to be geared to the reality of Plunket nurse practice and vice versa. This is implicit in Hope's experience with a nurse who told her that what was taught in class was "unrealistic." Another nurse claimed she was "just about killing" herself trying to do everything right, but then she said: "You have to let some things go. You can't be so involved trying to be everything to everybody. You go out with such enthusiasm, but you soon learn to do what you can and still remain sane."

A person, who began the basic nursing programme with little experience other than that gained in her family of origin and at primary and secondary school, and who was amongst those who had watched older women do so well in the comprehensive nursing programme, was ready for the Plunket course: "I never came across anything that I

hadn't learnt." Nevertheless, she had a number of recommendations to improve the course she had taken, recommendations which concerned assessment of clinical work. She said that tasks were marked as completed, but that "there was never a comment by the nurse on whether you'd done it to a satisfactory standard." Similarly, with respect to the appraisal forms that Plunket nurses fill in for the nurses who accompany them, she said: "I was really impressed by the way one nurse did my appraisal. She really asked a lot of questions. The others just wrote, 'Did this well.'" Mary recommended that Plunket nurses be given some help on how to supervise:

> The people who take you out need to have training in having students...One or two of the nurses I went out with were excellent at making me think the process through, and at giving me a better picture of what the reality of it is. Whereas other nurses viewed you as a hassle and didn't say , well, "This baby hasn't grown. What would you do about it?" And they never discussed with you what they were thinking or what their thoughts were about the family you were going to. Well I think that's not the nurses' fault. They're just given a student and it's assumed that they're going to be able to manage. I thought about it a lot when I started.

The problem of presenting material which students were not ready to learn emerged again here. Hope, who said several times that she found the practical aspects of the Plunket course most helpful, also said that there was a lot of theory that was "useless," which she could no longer remember. Nurses spoke about theory that was difficult at the time "to see." Lynn said, "I guess the group skills and things like that all seemed a little bit bizarre when you haven't been in employment for a while and you're not really thinking about it. It would be nice to do it later."

Further alternative ways of bringing theory and practice together within a classroom setting emerged. As well as the anecdotes (quoted above) that remained in memory, surfacing later as their corollary in real life became plain, several nurses remembered case study assignments, which required a combination of observational and theoretical components. Role plays and group work also operated at experiential levels, and Noreen mentioned how when she was faced with working with groups of people, she drew from her experience as a student required to present material to the class.

Lynn and Hope talked about administration as a problem area requiring more preparation. This too could be practiced in class so that students became familiar with filling in forms and with reference material such as handbooks before they began working on their own. Hope spoke about her experience:

> They reckon you can't learn the paper work until you're out on the job. You go over the notes and that sort of thing, but as far as actually knowing what report has to go in where, and what stats (statistics) have to be there, you don't go over that. And you get out there and you just feel swamped, because you're trying to sort out who has got to have this by that time, and what has got to go where, and how many copies have got to go to there, and it's just horrific. ...We could have had mock clinics where we actually learnt what went where...There

> was a lot of emphasis on how you write your reports...and the nursing process, but not much put into the actual stats and management of the clinic. A reference book would be very welcome.

Kate said that she would have liked to have learnt more about problem management and effective communication skills—a type of learning which also requires participation from students. Several of the nurses whom I interviewed had on their own initiative taken counselling courses in order to improve their communication skills. Hope isolated a recurring problem faced by the nurses:

> You're faced with someone who comes in with a sleep problem, but when you talk to them it's not that problem at all. It's all sorts of other things. There's not enough teaching on how to discern or single out what the problem is. So many times what presents is not the problem at all.

She also requested more on management of particular problems: "Scenarios —I don't think we had enough of that, so that we could work out amongst ourselves what to do in a given situation. That would have been ideal because that's what you're faced with more than ever out there." Mary would have agreed. When she talked about some of the dilemmas Plunket nurses come across, she said, "We never did much theoretical work on the process of a problem," I asked her if she could give me an example of a dilemma. She replied:

> The general practitioner and I and the paediatrician thought we were looking at child abuse. But when do you start to intervene? At what point did you need to go and see somebody to see if he's violent? When you were visiting there was violence in the home —booting the dog—violent with everything in the house except the baby. You wondered if he was not being violent with the baby because you were there. But verbally really abusive. And that's the pattern. The baby was physically doing well. There weren't any marks on the child. He had gained weight and theoretically he was doing really well. (It was) an isolated area . She was resistant to any input from anybody . She had one friend, who I had made a point of meeting and talking to, who definitely thought there were problems, but she (the mother) won't trust anybody. That kind of dilemma. What now? What do you try now?

Like Hope, Mary suggested that the course include sessions in which scenarios were presented for discussion to establish "a whole lot of different options" for action. Trish had found in-service education on how to respond when sexual abuse is suspected useful: "I feel a lot better about that —more confident." But she has had to learn "on the job" with cot death. She said, "With cot deaths— I've had two, and I've learned a lot from those."

Over-all the nurses talked positively about continuing education within Plunket. Lynn, talking about changes in theory about ideal infant feeding practices, emphasised the need for, and her appreciation of, a continual up-date on these. She also emphasised the need for nurses to have the opportunity to share with others. "It's a very lonely job."

Requests was made for extension or addition to topics within the course. Trish saw a need for more education for Plunket nurses at the practical level. She suggested teaching on how to get a baby on the breast and instruction on the less expensive alternatives to some of the current housekeeping practices. She said, "You can make do. You don't need a lot of money to keep a good standard of housekeeping." Trish also asked for more emphasis on, and contact with, people from different ethnic groups. Susan mentioned assertiveness courses, and then went on to talk about her personal interest in psychology and how she would like to see more of that in Plunket nurse education. She talked about the need for more teaching skills, since Plunket nurses now work more frequently with groups of parents and offer more group clinics. She also thought that an orientation to the community would be helpful: "You see when you go into a job you have to start batting straight away and you have to find out yourself what's available in the community... I feel as though I'm chasing my tail and I'm still trying to find out about the community. Well—what is available for my clients." Philippa began to make the case for a longer Plunket course and for more recognition for Plunket nurses:

> I don't think seventeen weeks is long enough. It would be really nice to see it made into a diploma course so that it had some recognition outside of the Plunket Society. I think that we covered a huge amount of things in seventeen weeks. All credit to the tutor. She is an extremely motivated capable person. I don't know if all Plunket courses are as good as what I perceived ours to be, but if it was longer, I think then there would be more time to go into more detail, and (it could have) a little bit more practical time so that you could have a lot more feedback in the classroom situation on what you are seeing and what you are experiencing.

In summary, when the nurses were asked what they would like to see added to the course, they offered a wide range of suggestions including: improved quality of clinical experience; more experiential content in classroom situations; more theoretical content; a longer course; and more recognition for the course itself.

Summary and Discussion

Because each new piece of knowledge becomes an intricate part of memory, ascertaining where and when something was learnt was difficult. However, there was a strong emphasis in these nurses' responses on the importance of experience. Information was assimilated more easily when it followed experience that was relevant to it or when relevant experience was offered along with it. Information attached to experience tended to stay in memory whereas information passed on in a didactic manner did not. When material was presented didactically, motivation emerged as an

important factor in learning. It was found that theory is learnt most easily when it can be related to knowledge already present in memory, and that theory can expand knowledge already present in memory. But the importance of the course material closely approximating the needs of the person learning it was stressed.

Among the suggestions offered by the nurses for future Plunket courses, there were a number that, if followed, would bring experience and theory together to facilitate learning. The value of placement with practicing Plunket nurses in the introductory Plunket course was emphasised strongly, with the proviso that these nurses were known to be practicing effectively, were not exhausted and had been shown how to make constructive student assessments.

Finally, when I studied the responses made to questions about education, I found that they revealed as much about the nurses themselves as about their formal education. This is particularly evident in the first section—*Learning from Life*. They saw themselves as learning, from their lived experiences, values and principles that included: tolerance, understanding, respect, and humility. They saw these attributes as essential to their work. Their words reflect the words of Lumby (1993a:1):

> If we are to examine our own process of education and preparation for practice then we cannot exclude the ways we live in the world as nurses...It is our ontology, which explains the way nurses act in and on their world and 'become' the person described as 'a nurse.'

Lived experience includes nursing practice, which also received emphasis in this study. Lumby (1993[a]:6) writes:

> ...the knowledge which exists in a well practised nurse is 'within' the nurse and comes from practising nursing. It is the knowledge which has been described in a variety of 'ways including 'tacit,' 'intuitive,' 'personal,' 'working,' and 'everyday." But it provides the link between book knowledge and effective practice. It is gained through experience in the real world and thus eludes students who are not exposed to the real world during their academic programme.

Lumby (1993a:15-16) perceives the need to facilitate the link between book knowledge and effective practice. Consequently, she helped to develop classroom strategies to facilitate the development of the "knowledge which exists in a well practised nurse." Most of these strategies involve introducing approximations of real life experience into the classroom. This kind of learning is crucial to the goals that the nurses in this study have for their work with families and for the establishment of what they see as ideal relationships with others (Chapter 7). It is this kind of learning on which the nurses themselves place very high, if not the highest, value.

Part Three: The System

CHAPTER 5

NURSES' VIEWS ON THE HEALTH SYSTEM

As I have indicated ('Introduction'), I am interested in the ways that the New Zealand health system is perceived, an interest that was heightened by the experience of working as a public health nurse. There are close parallels between Plunket and public health nursing. Both require an extensive knowledge of support available to families; that is, both require familiarity with the tangle that I have called the "health system" (Chapter 1). Consequently, when I thought about asking Plunket nurses about their reality, I wondered how they viewed the New Zealand health system. And I began the interviews by asking:

When you think about the health system, what sort of things do you think of?
What do you see as making up the health system?

In this chapter, I will present and discuss the Plunket nurses' responses to these questions, begin with their resolution of what to include in a description of the New Zealand health system, and continue with the concerns that emerged. The chapter ends with a section on safe practice which appeared as a major concern.

THE NURSES' VIEWS ON WHAT TO INCLUDE IN THE HEALTH SYSTEM

A Difficult Question

Just as I have found it difficult (Chapter 1) to sort out what might be included in a description or definition of the health system, many nurses also found this question problematic. Involved in the day-to-day pressures of work, many had not had time to give much thought to the larger context of their work. Some had not considered one or more of the practices I included in my framework under the heading The *Hybrid System* (Chapter 1) as part of the New Zealand health system, and they struggled to articulate their thoughts. To help them I asked additional questions, such as, "Would you see a city council supply of potable water as part of the health system? What about iridology or naturopathy—are these sorts of practices part of the health system?" As well as the difficulty of sorting out the tangle that is the health system, and the lack of time for reflecting on their work and its context, it seemed that some were also constrained by a certain amount of conditioning to see only biomedical treatment

services as 'the health system.' Beth suggested that this was so: "What I think about the health system? Well, the first things that spring to peoples' minds are hospitals...medical problems...surgical problems."

The Struggle Made Explicit

After about fifteen minutes of discussing the health system, Susan was explicit about the difficulty she was having: "You've made me think about just what's been under the surface which I've never actually—well—I've never talked about public health before." Mary experienced a similar struggle: "I know I tend to think of physical health, but the other—mental or spiritual health—is just as important." Hope also: "I guess it's more health of your body separate from your mental health in a way. Sickness is the big thing." Thus the medical model as a constraint on thinking about health became more apparent. Hope saw the whole system as dealing with sickness, sickness of the body in particular. When asked about voluntary agencies Hope said, "Like Barnados and whatever? They are more like social welfare agencies." Asked whether she would include the health protection services of territorial local authorities in the health system she replied:

> I wouldn't normally, but I know that that's the way that the new polytech course is going. They're making visits to places that I never would have thought of going to visit when we trained, but I know that's what they are doing. They're bringing all that into the health system. I find it strange, but when I really reflect on it—really think about it—I can see why they are, but I don't know if I myself would. It takes a bit of adjusting.

Underlying Hope's response was a growing awareness that the health system included more than medicine. She saw that Plunket's entry into social support services such as organising playgroups had a direct positive impact on health at individual, family and community levels. This created some confusion for her. When asked where she would place Plunket she said, "Health, definitely—well—originally health...now I'd rather put it partially in health and partially in social welfare." As she talked to me, Robyn thought through her ideas: "I see doc[tors]—Area Health Boards first, I guess—and Plunket—and general practitioners—I don't quite know what to go on about." When asked what she was thinking about, she said:

> Well, do you want me to talk about—yeah, health being important sports wise, people participating in sport? It's not really the health system I suppose—no. What else is in the health system? Basically Area Health Boards, which includes public health, district nurses, vision and hearing testing, school health—and then such things as community...I don't know whether you want me to go on about La Leche League and Diabetic Association and all those other things?"

I asked her whether she saw these as part of the health system and she replied emphatically, "Yes, totally. Yes. Yes." Then she continued to consider the agencies she worked with in her practice as a Plunket nurse, and she found that she saw them all as part of the health system:

> Social welfare, police sometimes, dozens of them really. I can't think of them all. Speech therapists, kindergartens, playcentres, kohanga reo, Maori Women's Welfare League, Maori health workers, health assistants (now that we've got one). With Plunket, of course, there are the volunteers who are most important, and the nurses, the medical officers...allergy awareness people, lots of homoeopaths and naturopaths and people like that—English as a second language, all of those people, the polytech people, yeah, yeah.

What to Include?

I could see that my first question required a lot of energy from some of these nurses. They did not find it easy to describe the composition of the New Zealand health system. Although most ended up including everything listed under *The Hybrid System* (Chapter 1) as part of the health system, one or two of the nurses were reluctant to include some practices. Wendy was comfortable with almost everything as part of the health system, except the work of voluntary agencies such as church social services, home budgeting, Birthright. She said: "Not in my opinion, no, not in actual health...People involved in that to me are not what I consider to be involved in the health system." She also had some difficulty with the health protection services of territorial local authorities. She began:

> Yes, because I consider you can't have good health unless you've got clean water and fresh air, but...you don't have to be a health specialist to be dealing with water. I couldn't go out and clean up the water system, but I think it should be cleaned up.

Susan would not include health services such as homoeopathy, or practices from different cultures, but she would not discourage people from using them:

> I wouldn't put them in—no...When people have come to me and said "Well, we want to do this and we want to do that," I think it's great. I mean when you've got your own sick child, (and) somebody can help. You will try anything. I say (to them), "Go for it if this is what you firmly believe. It could possibly work for you and if it does great. But if it doesn't (work)please come back to me or see your GP or go to the hospital." So I don't think I'd incorporate it. No.

On the other hand, there were some nurses who were clear from the beginning that their view of the health system included all of the practices listed under *The Hybrid System* . Trish articulated this:

> Well, the health system, you've got to have your hospitals and all your community services—doctors, church groups and education, kindergartens and home help

> and all those kinds of services that you need to help people. I can't think of all the health services...and education is another one for all walks of life and counselling and budgeting, all those sorts of things.

Kate said, "I see it as people first." Mary repeated this theme: "What I see as the health system, is a whole lot of different people from a whole lot of diverse backgrounds trying to work together with...a common goal, which is health." Philippa as well: "People, not so much families, but just human beings, and last, very, very last, right down the list would be the hospital side of things." She added that this was not the way that she used to think before she started community work. Working outside of a hospital had opened her eyes to a much more diverse health system than she had seen from within. It had helped her to focus more strongly on health as opposed to sickness. Beth, who began by articulating the existence of a cultural pressure to see the health system as confined to biomedical services, made it clear that her own view of the health system was far more comprehensive: "When I think of a health system I think that it is much bigger than just hospitals. I see that we have to look at health from when a baby is born until when a person dies"

The Comprehensive View

Asked whether or not she would include within the health system the work of a mother caring for sick children and teaching about health, Beth replied, "Health is total." She made it clear that for her any contribution to health is part of the health system. Trish, Kate, Mary and Philippa (cited above), by putting people first when asked about the health system, show that they share this view. Overall there was very little dissension from this position.

For example, Lynn, when asked about the contribution of parents to the health system, replied that as far as she was concerned they were definitely part of the system: "Mothers are probably the best people in the world. I say mothers, there are fathers too...They are intuitive and often know when to do things. They know their children." Fay would agree:

> It is, because that's where it all starts ...That role for the mother at home is, in my view, the essential part of the primary health (system)—mother or father, the caregiver, or the head of the family. And the head of the family could be the grand parents too, because I see that in many situations... If not living under the same roof they are getting together very often ...and that is...one of the areas where the knowledge must be based. If the parent or the main care-giver does understand about hygiene or preventing illness or looking for signs and symptoms of skin disease or whatever, or how to be careful if there is a contagious illness around, you are going to have much less of a problem. Or if they have the understanding, if they do get problems, of the importance of treating it early, that can be an enormous saving.

Asked about health practices associated with different ethnic groups, Mary said that these should be part of the "mainstream" health system. She continued, "In New Zealand they're not well accepted within the system, but there's no reason why they shouldn't be and they could be. They don't seem to have the right to practice their health practices in the way that they want to." Asked the same question, Lynn replied, "Yes absolutely, that's one of my own pet things." Fay emphasised the importance for more understanding and more support for these practices. All nurses included these practices as legitimate. Hope said, "I think that their health practices or health customs or systems ...have to be respected and they have to be [included]." Wendy, who was comfortable about including different ethnic practices in the health system, commented: "I think that for us all to live together we should all understand each others cultures."

In summary, several nurses, asked about the health system, began by discussing biomedical services and then branched out to other health services, some discussed the difficulty of seeing a health system in terms broader than medicine, while others had already developed clear views of the New Zealand health system as encompassing a wide range of practices from all levels of prevention. All of these nurses included the majority of practices listed under *The Hybrid System* .They saw the health system as a complex patchwork of services and they emphasised people first. Philippa made this very clear: "In order to have a health system that works efficiently, it's important to see what are the needs? What is it that people require from the health system? Otherwise you are wasting time and money."

Concerns about the Health System

At some stage, all of the nurses participating in this study expressed concern about the health system, but a few **began** by talking about these concerns. This initial question acted as a trigger for their disquiet which over-rode all other thoughts. These concerns, uppermost in their minds, arose from what they saw as inadequacies or threatened inadequacies in the health system.

Several were concerned about waste occurring because resources were directed more towards treatment than towards prevention. For example, Lynn observed, "What I see happening is very much hospital care rather than primary health care or prevention or promotion." Immunisation can be used as an example to why this was a concern. When a certain percentage of people are immunised against contracting a particular disease, epidemics of that disease cease. This has happened in New Zealand with diphtheria, tuberculosis and polio. However, should immunisation levels drop, there

will be further epidemics of these diseases with enormous cost in both monetary and human terms. The cost of immunisation against these diseases is far less than the cost of treatment. Beth summarised a number of areas in which prevention would save this kind of waste:

> One of the things that really...angers me, is that with all the health organisations (we have) we are not prepared to spend any substantial amount of money on preventative health. We don't use the media that people look and listen to, that is the TV. We publish lots of pamphlets. Now we have even cut down on pamphlets. It is not in the interests of industry to act to promote health. Health means different values, less emphasis on material goods, healthier life style which means less purchasing of processed edibles, cigarettes and alcohol, women less dependent on make-up and fashion. They're cutting down on the time of Plunket nurses and I see ourselves as in the front line of preventative health workers, so that really worries me a great deal...The Hillary Commission is doing a very good job of making people aware of physical exercise, they've come out with some lovely new books on baby massage which I think is wonderful, because that teaches people a whole lot of skills about well-being and they can use that in their family with their children as their children grow up. Touching and stroking is a very important part of life...Healthy eating—we have started a little bit about that, but I think it's got a long way to go. The drink and drive problems that we have. I think the Government and the health people have had a very half-hearted look at this. Other countries in the world can stop the drinking and driving, but our lot are not willing to put a stop to it. It's a political decision that we have so many beds occupied by road accidents and the same with drug abuse. I think we need to put a lot more energy there...A lot of our health education is not as efficient as it could be.

Fay was not so specific but she voiced the same concern:

> I felt that New Zealand did have a good health system, a very good health system, but working in the health system in both a public hospital and a private hospital and now with the Plunket Society I have seen a lot of wastage, a lot of waste money, a lot of waste time, a lot of wasted energy, where things haven't always been directed in the areas which I think are more important. A big emphasis on illness instead of wellness and that hasn't changed a lot, sadly. So there are a lot of good things about the health system, but I see a lot of bad things too.

Fay was concerned also about public ignorance of the value of primary health care:

> People get very upset when they have to pay something because they are going in to hospital. They are not getting very upset and not even thinking about the cuts that are being made in the primary health areas. Where the facilities are there, they are not utilising them because they don't understand, and that is really hard. And a lot more emphasis has to be put on that—really very much so —not just through the health services but through the schooling system, through everything...People have to be thinking about wellness.

Susan saw wastage in terms of people not using a service that would benefit them:

> I think there's a lot of slack. In other words, I think there is a lot of wastage when I do my work. For years and years I was in the hospital and you do certain things and people are sick and so obviously they need your care and you feel quite needed. When you get into the community, (into) community health you realise that it's an option that people take up when they want it, whether it's needed or

> not. I think there's a lot of slack there. I think a lot of people who don't take up the option actually do need it.

Noreen's observation tied in with the work of Salmond (1975), Briggs and Allan (1983) and Norton (1990), all of whom found support for Hart's *Inverse Care Law* (1971):

> Now I've got people who aren't taking themselves to the doctor. They just can't afford the cost. Now that they've changed it, a lot of people in my area only just fit in to the third group,[1] and they're having to pay twenty dollars to take a baby to the doctor. If they're told to go back the next day, that's another twenty dollars. I've had mothers tell me about the horrendous sums of money that they've spent by the time they've been, or a child's been, and they've got their prescriptions. I really think that the Government is not doing the right thing. I think it's a shame, I really do, but they (Government) are not seeing what's actually happening.

Anxiety was expressed over the lack of integrated planning in relation to Government policy and administration of health services. Lynn's words echo those of Fraser (1984:53) "In essence, it is a patchwork of provisions which are the result of ad hoc, pragmatic responses to an ever changing mix of economic, political and ideological factors":

> The other thing I see about the health system is that there doesn't appear to be any genuine long term planning...The general perception I have is that the health system as such is quite chaotic at present, and that it would appear that different governments come in and change what the last one has done. It seems to me that a large amount of money, would be better spent if different parties got together and actually looked at the long term planning.

Talking about the need for closer links between hospital and community, Noreen expressed concern about rising costs caused by the introduction of increased levels of management: "I think they're [hospital and community services] getting too top heavy with too many managers, and they have a secretary, and they have a computer." Kate expressed a related concern, adding that generic management brings with it administrators who are unfamiliar with effective health practice.

> I see it from a health perspective—whereas these days it seems to be a management (perspective), and I'm not interested in it. I know it has to be, but I think they've got it all tied up and people are managing health systems in this country who don't really know anything about health. It makes me angry because then the public are not getting the service they're paying for from their taxes.
> ...I think that how we had it was good, but I think that probably it was never streamlined enough. I think perhaps the good years have gone because of waste. I think there has been terrible waste and perhaps they didn't have enough accountants doing a good enough job. I don't think it was a solution putting managers in talking about health, but I think they should have had managers in talking about money a long time ago, because now it's all gone.

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[1]The "third group" refers to the people with higher incomes who are required to pay all medical charges.

In summary, some nurses expressed disquiet that the health system is biased towards support for services for treatment to the detriment of services with a health promotion, health protection focus. As they saw it, this is one reason why there is waste within the system. Other concerns were about waste that arises when people do not use appropriate services available to them, either because they are not informed about them or because higher charges for medical services were a barrier to access for some families. One nurse saw a need for long-term planning and there was further anxiety that new management structures will cause added expense and take money from service programmes. All of these concerns are, in one way or another, concerns about waste: waste of money and waste of people. Concerns about safety of practice also surfaced, and in this part of the interview these mainly related to health traditions other than the biomedical one. Unsafe practice also leads to waste, but there were sufficient comments about this to warrant it a section of its own.

Safe Practice

Every nurse, at some time during the interview, expressed concern about safe practice. Sometimes this concern was directed towards their own practice (for example see Chapter 3), but the following responses were made in relation to those practices which are alternative to medical practice (for example: naturopathy, iridology, health practices within cultures other than Pakeha).

While most of the nurses accepted Pakeha alternatives to medical services as part of the health system, a few were cautious about their approval. Trish was one of these: "Some things will work for some people, but it's not the answer for everything. I think if they want to have a try, let them have a try." When pressed about including these practices in the health system she replied:

> Yes, but as long as they don't push. With some of them, I have a feeling that they push too much. They push their ideas onto people instead of just saying what they have to offer. People spend a lot of money that they don't really need to on these things, whereas a good basic diet, for example, would probably do them a lot of good. But some people do get relief from them. I think they do have things to offer.

Kate, who thought it was better to include than to exclude, said: "I think there is a place for them. It's better to incorporate it all rather than [to have it] sit on the outside because there is a danger then of it just being used alone and by the wrong people. It could endanger health more." There was agreement in what Fay and Philippa said about the

accountability on the part of people delivering a health service to the people using it. Philippa stated:

> Any deliverance of health service within a cultural framework again needs to be accountable, needs to deliver a good service, a safe service. And within every culture there are good things to do with health and bad things. So deal with the bad and improve the good.

Underlying these statements, there was perceived to be a need for a system to protect people using all health services; a need for registration of practitioners, for ways of monitoring the effectiveness of the services, and for avenues of redress should the services fail in some way.

However, there was another side to safe practice. Namely, that people have a responsibility to use the services available wisely. Lynn said, "They are all options that people have...providing people are sensible about their use of services." Robyn expressed a similar opinion, and Wendy too:

> I think they've (alternative health services) got their uses and certainly they give a lot of people relief, but I do think that before people get too involved in any alternative medicines they've probably got to make jolly sure that it's not going to be detrimental to the condition that they've got.

Fay talked about people playing a key role in their own health care and therefore reducing their dependence on health services. A number of themes present in the nurses' responses revolved around ideas about self responsibility, independence and a person's knowledge of the health system.

In summary, safety was seen as having two aspects. One related to the responsibility of the person using the service to be informed both about the service and about good health practices. Fay suggested that Plunket nurses could play an important part with regard to this aspect. The other related to the responsibility of the people offering the service to ensure that the service delivered what they claimed it would.

SUMMARY AND DISCUSSION

With approximately half of these nurses, it was immediately apparent, that questions concerning the nature and composition of the health system were not easy to answer. Some nurses were explicit that it was difficult to "see" the health system as extending beyond medical services. However, it eventuated that any practice that worked towards the goal of improved health status was worthy of inclusion, and that all of the participants included most of the practices listed under *The Hybrid System.* Strong emphasis was placed on the people using the services rather than on those setting policies, administering or delivering the services.

These questions also triggered concerns (uppermost in the nurses' minds) about the health system. These concerns were that: there was a bias towards treatment services to the detriment of health protection and health promotion services; some people were not using services when they could benefit from them; there was a lack of long term planning of health services; and that money was being channelled into management structures and away from health services. Noreen reported that sometimes people were not using services because of factors (eg. costs) outside of their control. The importance of accountability in relation to safe practice, both on the part of the service provider and the service user, was also mentioned. All of these issues were seen in terms of waste in the system.

There are, in this chapter, themes which continued to emerge throughout the interviews. For example: the strong focus on health, when many think of the health system in terms of sickness; the strong emphasis on the people using the health services as key actors in the health system; and the need for more accountability on the part of policy makers, administrators and service givers towards those receiving the services. A dominant theme that runs very strongly throughout the interviews like a deep undercurrent, not always clearly articulated but always there, is connected to the issue of dependence/independence. This theme underlies what Fay said about the need for more education so that people make good use of the facilities available to them. It is connected also to the emphasis that each nurse placed on health promotion.

Many of these nurses had moved or were moving from a medical orientation to the biopsychosocial orientation attributed to nurses by Pender (1987:33). Their responses support Pender's view that nurses see health in terms of "actualisation of human potential through integrated functioning of individuals and groups in interaction with their environment." Along with this holistic orientation is a strong focus on the people using health services. To repeat what Philippa said when asked, "What is the health system?":

> People, not so much families, but just human beings, and last—very, very last, right down the list would be the hospital side of things. Which wasn't how I used to think before I started community work. Therefore, to me, in order to have a health system that works effectively, it's important to see: What are the needs? What is it that people require from the health system?

This statement, like many others from these nurses, in emphasising the importance of the people who use health services, echoed the WHO declaration on primary health care (WHO 1978:34):

> Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

The Plunket nurses participating in this study were centred not on treatment of sickness but on health for people. Consequently, a health emphasis was strongly present in their comprehensive view of the New Zealand health system.

CHAPTER 6

PLUNKET'S PLACE AND VALUE

The central concern within the previous chapter was Plunket nurses' perspectives on the New Zealand health system. In this chapter, I shift the focus to the Plunket nursing service. I asked the nurses participating in this study how they saw their work fitting into the over-all health system, what they saw as the value of the Plunket nursing service, and whether or not their perception of Plunket was shared by other health workers (including other Plunket nurses), the families using their services and policy makers. The responses to these questions are summarised and discussed in the order listed.

PLUNKET WITHIN THE NEW ZEALAND HEALTH SYSTEM

How do you see the Plunket nursing service fitting into the New Zealand health system?

In the previous chapter, I mentioned that placing Plunket nursing services wholly within health services was problematic for Hope. She concluded, "The way things are at the moment I have to put it [Plunket]...in with health...[but] I'd rather put it partially in health and partially in social welfare." Although the remainder of the nurses interviewed saw Plunket as part of the health system, many had difficulty in specifying Plunket's place within it. Mary saw Plunket as part of the health system, but remarked that it was "a bit isolated." However, this was not her personal view. As far as she was concerned Plunket nurses offer an important health service: "I see what we do as really important...I think it is essential child health care, but I feel that in the [popular] view of things Plunket is a side service." Mary described what she saw as the generally accepted view of Plunket and the generally accepted view of the health system, and concluded that the two together appeared to make Plunket incidental to mainstream health services. This would fit with the concept of 'the medical system as health system' (see Chapters 1 and 5). Mary acknowledged a tendency "to think of physical health [first], but added that, "mental or spiritual health is just as important." In the course of the interview she made it clear that for her all levels of prevention were important and that Plunket was mainstream within the array of health services.

Susan appeared to overcome the limitations of the notion of "the medical system as health system" by developing the idea of a separate community health system. To Susan the health system appeared inflexible and unhelpful, while the community health

began with Plunket's role in linking key people together. For example, Philippa ("We can be a point of reference to other services"), Wendy ("Plunket networks amongst it all") and Beth:

> Within the health system we are linked to G.P.s....I have a very good liaison with the general practitioner who I work with...I think we are really networking. That's how I see myself as a networking person. We can so often bring people together in a way that they can support each other. I see that in the playgroup...I refer people to the dental nurse...One of our nurses visits the maternity unit twice a week.

In this quote, Beth has talked about linking at both the service user and the service provider level.

Like Susan (see above), ideas relating to primary health care were important for Kate. Kate began her discussion of the Plunket nursing service in terms of primary health care: "I think we're primary health care givers...high up on the scale of health...We are right there at the nitty-gritty stage—at the beginning—It's a really important stage." Philippa, expanding on the view of Plunket nurses "there at the beginning," saw Plunket's place in terms of its focus on family: "It [Plunket] is specifically targeted towards family health and that's a very important part [of the health system]. Well that's where health begins for most people—in a family setting." The theme of working with the **whole** family was universal amongst the nurses interviewed, and they placed Plunket within the health system by way of this focus.

Several nurses, who emphasised a family focus, added the idea of Plunket nurses working at the first level of prevention. Fay, for example, began with a statement about nurses offering health promotion and health protection services and then went on to emphasise the importance of working with a family as a unit.

> I see a Plunket nurse primarily as a resource person; as an educator and helper in preventing illness, and not just for the baby but for the family as a whole. ...The family is not one thing. It is a whole unit and it has to be looked at that way. I feel very strongly that the primary focus is perhaps the baby initially, and the care-giver, but it really can't be broken down. It has to be looked at as a whole. I see myself as a family nurse...

Beth, connecting giving support to the whole family with health promotion and empowerment, concluded: "I see Plunket as...teaching mothers to recognise when something is wrong and what to do about it. I see us as giving families skills to do things themselves—not just to rush off to the doctor." Both Robyn and Noreen placed Plunket within the New Zealand health system according to its focus on prevention. Noreen said:

> (the Plunket nurse is) preventing accidents, she's preventing illness, or preventing illness from getting worse. She's really trying to prevent problems before they arise, and that's for all sorts of things...Sometimes you are the only person that the family has and so you might get involved in things other than health. You might

> have to help them go to the Housing Corporation...they might need counselling. It's not just physical health. It's total health.

Therefore although she began with prevention of physical injury or illness, Noreen ended by indicating the breadth of Plunket nursing and the breadth of a Plunket nurse's approach to health. The focus is 'total health.'

In summary, most of the nurses saw their work in terms of primary health care and primary prevention in family and community settings, but it was not easy for them to place their work within the over-all health services. It is possible that the dominant position of the medical model within the health system was a complicating factor. Mary pointed out that there was dissonance between her own view and what she saw as the commonly held view of Plunket within the health system. Hope overcame this difficulty by dividing Plunket nursing services between health and social welfare, while Susan saw health services falling into two separate health systems, and she placed Plunket services within what she called "community health services." Prevention, starting from birth, was a major theme, but within this theme there were multiple foci including: the infant, the family, health protection, health promotion, empowerment, creating and maintaining social networks. These responses to the question of Plunket's place within the health system offer further support for Pender's (1987:33) claim that nurses define health from a biopsychosocial orientation. The Plunket nurses who participated in this study saw Plunket services as embracing all aspects of health; social and psychological, as well as physical health. This biopsychosocial orientation appeared to underlie the difficulty these nurses experienced in placing Plunket within a health system commonly defined in a rather restrictive fashion to include only the treatment of physical sickness.

THE VALUE OF THE PLUNKET NURSING SERVICE

What do you see as the importance of the Plunket nursing service?

As explained earlier (Chapter 1), at the time of the interviews a process of re-structuring had begun within The Royal New Zealand Plunket Society. Plunket nurses were facing an uncertain future, and, given the changes to the overall health system proposed by the then current National Government, there was even a question mark over the continued existence of the Plunket Society as a national organisation. Perhaps because of this uncertainty nurses stressed the importance of the Plunket service throughout the interviews. For example, when asked about the health system, Fay replied: "I feel that we have a very important role." Asked if she could be more specific, she reiterated and elaborated:

> I see it as a very important role...it hopefully gains...healthy families; healthy children—well-developed, no illnesses, or if there are illnesses that they're rapidly overcome; parents who are enjoying being parents...all of those things. They don't all happen, but at least we have an opportunity of going in there and trying to let it happen. I see it as the most essential care within health care. Not just because it's my job. I mean I'm in the job because I feel that way.

Although Fay was stressing the value of Plunket , she asserted that she was not doing so out of self interest. She was working for Plunket because she believed that the work was "essential." It was the kind of work that she wanted to do. This was the case with each of the nurses who participated. Each was adamant about the value of this kind of work regardless of which agency administered and delivered it. Fay's response was a good example of how answers to this question overlapped those to the previous question. In the following I will give examples of statements representative of the different themes that have already emerged, and then continue with new emerging themes.

The principles underlying primary health care[1] featured in many of the responses as participants discussed the importance of their work. Kate and Hope talked about the value of Plunket in terms of its accessibility, with Kate adding that it was a free service. Beth also emphasised that the Plunket nursing service was essential and affordable.

Kate, when looking at the worth of Plunket, also elaborated on what she had said about the place of Plunket. She emphasised the focus on family, the idea of being an initiator, there at the beginning of a person's life, promoting health and empowerment:

> We're dealing with the beginning of a new life and we're dealing with mothers at the beginning of their new careers. We have an enormous influence on the welfare of them as a family and on their children's future. We can have that by our attitudes, by our promotion—not just of physical health—by our whole promotion of living and caring. We can have an enormous influence on that future family; the future carers of the world...I would like to think that my particular influence empowered people to be confident ...that they are doing the job well. That's what I would like people to think I had done for them rather than see me as someone who had solved all their problems. I'd like to think that through me they felt that they could do it.

Mary described the relationship that Plunket nurses have with parents as a resource for parents. She saw this relationship as a "form of reassurance." Because of it parents "know there is someone there for them and for their child." And the child benefits: "If you are supporting the parents, then that will filter down to the child." Lynn, concentrating on support to families, endorsed the idea of a Plunket nurse as a resource:

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[1] "Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community" (W.H.O. 1978:34)

> Our main role is probably supportive. Supporting parents in their care of children and particularly when so many of the families that we see have no extended family...the support of the parent's bonding (with the child), so that the parent's are able to enjoy the child, which results in a whole lot of positive things for the child. To feel loved and wanted. That's the initial thing. Then the actual health things. Giving parents up-to-date information on things like immunisation...Health assessments to screen for any problems and referring on when necessary...The developmental delays, parents don't recognise them. We play an incredibly supportive role there. Children get support and they have an opportunity to catch up.

The themes of support and empowerment continued to be very apparent. Trish, Lynn and Mary spoke about helping to enhance the quality of parent–child relationships. Robyn elaborated on this:

> We're aiming to help people enjoy their children and to give (them) a good lifestyle. We are there to see that children are cared for. Get their basic needs met. ...To have every opportunity to learn to become good citizens. If that's not done in the first five years...their long-term future wouldn't be so grand. ...We don't just focus on the child. We try to help the parents. ...A lot of the work we do is supporting the mother and father.

Trish, picking up the theme of empowerment, talked about helping the family help themselves, "so that next time they can make the decisions for themselves instead of always being dependent [on us]." Beth spoke specifically about support for fathers: "We have some good booklets. One is advice for fathers...They also feel the change." Hope recognised the value of women working with women:

> The fact that it's often women helping women. Mostly we are working with women. Being there, being available, so that they've got someone to talk to, someone they can ask. Not necessarily telling people what to do, but to be a listening ear...so that they can make the decision that's best for themselves.

A new theme which began to emerge with this question, was that of the role of home visiting in assisting the development of a trusting relationship between nurses and family members. Under the contract with Government, that was current at the time of the interviews, the number of consultations that a Plunket nurse was required to make per infant were drastically reduced. The reduction in home visits was of such concern to the nurses that they returned to it again and again in the interviews (see Chapters 7, 8 and 9). Two or three home visits during an infant's first three months of life were seen to be insufficient in many instances. Fay's response, when she talked about young mothers, was representative of the others:

> I see it as a very important role that I am out there. I have to spend a lot of time with young girls (and) I can't rush in there and do everything at once. They've got to build up trust with me and a respect for me and that doesn't happen in one or two visits. That takes a long time. I know that when I have built up a trust and rapport with people that I can start to get through, but it can only be done on a one-to-one basis. It can't be done in a group situation.

> ...It just has to be done in the home...I am working in what is considered...an at risk area. Any input that we can get in, whatever it might be is important. I mean the scary stories, the scary facts of the abused and neglect that's around there. If nobody's going there, a lot of it's not going to be picked up. We can get in there. See it perhaps developing and prevent it from happening.

Because the amount of information available to a nurse visiting people at home is far greater than the amount available when someone makes a clinic visit, nurses were able to develop a deeper understanding of the family's situation through home-visiting. Beth emphasised the importance of a Plunket nurses' knowledge in terms of its uniqueness. This distinctiveness rests on the fact that Plunket nurses **do** see people at home:

> The importance of the Plunket nursing service is the view that we have. We have a much better picture of how a mother feels when she is at home. We know that when anybody has had a baby, it is a vulnerable stage of your life. To go there and just listen and see if we can understand what the mother's most important need is and just give her the information—as much as she can cope with, and that she can use—and also for other members of the family.

Community Level

Many of the nurses had not given much thought to their work in terms of its effects within the community. However, some were ready for the question. When I asked about the value of Plunket at community level, Beth talked about the positive effects of bringing house-bound people together:

> We are doing more group sessions with people which brings people with babies of the same age together...and they realise that they have a lot in common. They start to share a lot of information. I think that's a very important role for us. ...It's particularly important when mothers have been at work or are fairly young and have just left school. They have no social group any more, and it's only when you are visiting that you realise how many very lonely people there are. When you are very lonely you start showing signs of depression...People are social beings. We are not made to sit there all by ourselves all day. People miss the communication with other adults. You love the baby a lot, but it doesn't mean that you can talk to the baby at an adult level. Men don't understand how lonely it can be for a woman to be by herself all day.

Similarly, Susan, talking about loneliness, emphasised her role in helping people to develop self esteem; to feel better mentally. She said:

> In the area where I work, which is mainly lower socio-economic, they haven't got money for transport, they haven't got cars. In other words they can't move around all that very much...They are thrown out of hospital or leave hospital if they want to very, very early. They don't even see the woman in the next bed...So we get group clinics going so that they can meet each other. They need it. They need it for their mental health. They need to know they are doing a worthwhile job. All the time Plunket are trying to put that in their minds, "You are doing the most valuable job in the world."
> ...When they have built their own self-esteem they can reach out into the community and build community self-esteem up.

Again, empowerment can be discerned here as a powerful underlying theme.

Susan and Beth talked about their community work in terms of group work, but Mary was seeing community work in even broader terms:

> Just in terms of working in one community and beginning to appreciate the strengths and weaknesses in that community. You begin to see what would benefit the whole community. You can do things that would benefit not just one family but the whole community.

This statement revealed a heightened awareness of the possibilities for action open to a community nurse. Mary saw her work in terms of community development.

National Level

National campaigns such as advocacy of the use of safer car seats for children and Plunket participation in the campaign for the prevention of cot deaths were given as examples of the value of Plunket's work at the national level. For instance, Lynn said:

> The joint project with the cot death society has had amazing results...Three years ago you were never sure whether they (parents) wanted to know about it. Now everybody talks about it...Parents are anxious, but not to the point that they were a few years ago.

Unlike Lynn, many of the other nurses were not ready for this question, but when prompted, they described the positive outcomes of their work. They re-stated much of what they had already said about the value of support and understanding for families, the value of education, the value of assessment leading to early diagnosis and intervention. They described this work in terms of its positive impact on national health statistics. All nurses talked about their work leading to a better start for children because of the quality of the support they offered families and because their health assessments lead to early diagnosis and early intervention to alleviate any problems discovered. Fay said:

> You don't think about it very much, but it is absolutely essential...If there is a problem area—vision, speech, hearing or developmental delays—the sooner that they are treated the better...If we can get help for them...long before they've got to school there's a greater chance that those children are going to lead relatively normal lives.

Susan made a statement about Plunket nurses helping people to feel good about themselves and their children, the growing self esteem within the family having a positive effect upon the community, and eventually resulting in a healthier nation. She

said: "That's what we are doing. I don't know if other people are seeing it that way, but we are. And it's women...helping women."

Part of the problem of pointing to the positive outcomes of Plunket nursing at this national health level, is the invisibility of the work. Plunket nursing is private, taking place behind closed doors, preventive rather than remedial, and somewhat nebulous, as it involves trust and strengthening relationships. Even Plunket nurses find it hard to see the results of their work. For instance, Fay, on the theme of prevention, ended with the difficulty of measuring the effectiveness of Plunket nursing:

> We are...preventing a lot. Reducing the risk of cot deaths. Looking for signs of possible problems and dealing with them when we see them...I think that we have prevented a lot, but you could never count it. You can't say "Well she's been in there and she's stopped that happening."

One way of seeing the results is to compare the difference in parental care between that given to the first and second infants. Kate was amongst the nurses who did this:

> Sometimes we've had mums in and they've sat the baby out here (indicating away from the body), and a cup of tea here, and the baby's back against the table, but now she's taking up the baby and holding her close to her. It's so different from what it was (like) with the first. And I think that in two years she has grown a lot.

Beth, re-introducing the theme of making links with others, provided another answer to concerns about the invisibility of Plunket nursing. She talked about working closely with kindergarten teachers, kaitiaki from kohanga reo, a speech therapist, school dental nurses, general practitioners and an educational psychologist. Then she shared some feedback received from a primary school principal:

> The Principal was just saying, "With all the children that are now coming into school, the problems that are there have been dealt with." They don't have to start sorting things out at school...They now see the importance of problems in families being solved in the early years, not waiting until the child goes to school, so they are giving the psychologist extra time. He is now coming to our playgroup (begun and run by Beth) twice a month and he is starting a group at the intermediate...I think that there is an overwhelming response from the mothers. They will come to see the psychologist—even mothers who don't come to the playgroup. He is someone they can talk to.

Therefore, the work of Plunket nurses is not completely invisible; it is witnessed by families using the service, by the people who work alongside the nurses, and by school principals who can give feedback on the health status of the children entering school. In the latter case, the feedback relates to the work of a number of people including that of the Plunket nurse. Talking about what gets into the media, Fay returned to the idea of invisibility and she too offered a solution, but a different one from Beth's:

> Why isn't there a spokesman out there trying to get more across?...I've seen a few things on television...which are really good. Plunket should be at the

> forefront, but it's Phillips who are paying for it. Preventing burns and preventing cot death...Why can't Plunket be...having their name there? Why can't they be saying, "Come and discuss it with your Plunket nurse if you want more information?" You very rarely see anything about what Plunket has been doing ...in a positive light. It's not even asked—nobody bothers to ask us.

A positive image for Plunket was also one of Robyn's concerns when she talked about her personal goals and others touched on it as the interviews continued.

The nurses in this study had an extremely positive view of the value of their work. So much so that they found it difficult to imagine New Zealand without something like a Plunket service. Hope, describing Plunket nursing as "essential," said, "If it wasn't happening it would ...be taken up by places like medical centres." Beth saw "a large increase in families experiencing great, great stress" should Plunket services cease. Noreen listed some of the activities that would disappear: "primary health care... maternal health care... child surveillance... parenting courses...I think that total family health would be affected dramatically if there was no Plunket nursing." Wendy expressed sadness, irritation and frustration when she said:

> It's knowing that there are an awful lot of people out there who are working for society who have probably got it right, but in lots of cases aren't getting the credit for what they're doing...just hoping that it's not going to be destroyed by the silly health system that we've got going at the moment ...It's quite frightening that the whole thing could be dis-established overnight.

In summary, the Plunket nurses I talked to were adamant about the importance of continued home visiting, which they saw as giving them their distinctive and comprehensive understanding of the families using their services, as being essential in helping them to establish trust with these families, and therefore, as necessary to the positive outcomes of their work. They were in agreement also about the value of their work. They saw it as supporting and empowering people at home; supporting health development and community development; operating at the level of primary health care and at the of primary and early secondary levels of prevention (Pender 1987:4-5). Thus it helped to improve the health status of families, communities and the nation.

THE PERCEPTIONS OF OTHERS

Plunket Nurses

Do you believe your perception of Plunket is shared by other Plunket nurses?

All those interviewed had similar views on the work of Plunket nurses, but there was some slight variation over whether or not other Plunket nurses would agree. Mary and Beth were the most unequivocal. Beth said, "I think Plunket nurses agree about

what Plunket nursing is about." Philippa wasn't quite so sure: "I hope so...A lot of more recently trained women probably think along these lines...probably half the nurses think the way I do."
Wendy offered some suggestions as to why Plunket nurses might not be in agreement about their work:

> We are all individuals and we've all got areas that we consider to be more important than other areas. That area that you are most interested in is probably the area that you pursue more, and there's probably quite a number of nurses who will totally shy away from having to do one aspect of our work and be very comfortable with doing another. That's how it should be. We can't all be experts in the same thing and we wouldn't want to be.

Philippa, citing women's health as an example, said that it was up to individual Plunket nurses to decide how much energy they put into different aspects of their work. Fay saw some differences in attitude arising because each nurse adapts her practice to meet the needs of the people in the area in which she (he) works. However, the consensus was that overall Plunket nurses' views on their work are in agreement.

Health Workers

Do you believe that your perception of Plunket is shared by other health workers—paid and unpaid?

The image of Plunket became a central issue in response to this question. Themes emerged which were repeated chorus-like throughout the interviews. One of these themes had Plunket nurses as the 'Cinderellas' of the health system. Mary, for example, said, "People look and say, 'But you're only a Plunket nurse!' When I worked in a hospital they said, 'What are you going to Plunket for? It's the last place on earth!'" She talked about how difficult these attitudes were for her to accept:

> I have had a lot of difficulty in my mind with the fact that you can work for one organisation and be well esteemed and work for another and be not esteemed...I am the same nurse giving the same quality of work...Hospital is highly visible but it's a small part of the health system.

This is consistent with Mary's comments when she discussed Plunket's place in the health system. In essence, Plunket nurses were not highly regarded by other health workers, including other nurses. According to Lynn: "There's a feeling that Plunket nurses are at the bottom of the heap when it comes to nursing." She saw the Plunket system as being partly responsible:

> ...I guess it stems from the Plunket system as such ...a feeling like we're not given the professional status by the Society and by volunteers. Often the volunteers, whether they intend to or not give the feeling...that you are working for them.

The relationship between Plunket volunteers and Plunket nurses often appeared as being problematic, and became an on-going point of discussion in the interviews. At the end of the above statement however, Lynn added, "[It's] better now than it has been in the past...Not all volunteers are like that." Therefore, in Lynn's experience this relationship was changing for the better.

When asked whether other health workers saw Plunket in the same way that she did, Hope replied:

> I don't think so. I don't really think they see the extent of what we do. Some general practitioners and practice nurses do and some community services, but it's not across the board. I think it would be quite isolated cases—individual people.

The invisibility of Plunket nursing, 'not seeing and therefore not understanding' was a prominent theme throughout the interviews. However, Hope's response allowed for some individual variation, as did Lynn's when she was asked if nurses working in different agencies and different capacities (in hospital, with general practitioners as practice nurses, as public health nurses) would have different views about Plunket nursing:

> I think there are some nurses in all of those areas who would put Plunket nurses up here (indicating high standing) and others who would put Plunket nurses down here (indicating a low position), but within nursing as a whole, Plunket is perceived as being not very far up the hierarchy.

Lynn added that health workers who visited at home as Plunket nurses did, saw the wider picture, and therefore, understood the role of Plunket nurses a "great deal more" than those working only in a hospital or clinic. She mentioned workers with Birthright, Barnados and Open Homes (all voluntary agencies) as examples of those with the broader viewpoint. In a similar vein, Philippa said:

> I think public health nurses have a good idea of what a Plunket nurse does...basically we are doing a very similar thing...I've found that if you have contact with a social worker who has had a positive contact with a Plunket nurse, then they understand. Otherwise it is re-education of a sort for them. Sometimes we are doing similar things with families, so social workers would be next on my list. Pre-school educators understand what we do. With practice nurses it depends on her general practitioner's attitudes to a large extent. If the general practitioner felt that Plunket was superfluous, or that all that (Plunket) nurses do is weigh babies, or that nurses shouldn't be an independent practitioner, which is common in (this town), then the practice nurse is often antagonistic.

One principle underlying what these nurses said, is that those who understand the work of Plunket nurses best are those whose own work is closest to that of a Plunket nurse.

This seems like a tautology, but it attests to the invisibility of the work and the consequent inability of outsiders to understand what it is that Plunket nurses do.

Change was apparent throughout the interviews as a motif. One of the themes of this motif was the improving attitudes of other health workers towards Plunket nurses, including the attitudes of general practitioners. Trish, Philippa and Lynn talked about doctors becoming more receptive to their work, with younger doctors less arrogant than older ones. Lynn said that she appreciated a doctor treating her as an equal, adding, "...it's really neat. There are more doctors who are this way." Beth, talking about the frequent referrals she made to general practitioners, said, "I have very positive feelings about the general practitioners—never a query if you refer a person." Susan reported that some general practitioners were "superb" in the way that they related to Plunket nurses while others were "terrible," and she added, "They could say the same about us." Wendy offered some insight into the relationship between general practitioners and Plunket nurses:

> Some general practitioners really value Plunket nurses and the knowledge that Plunket nurses have. They will openly admit that their knowledge of paediatrics and under fives is very limited because I think they only do six weeks during their medical training, whereas we do considerably more than that. They are also aware that because we are dealing with well children all the time it's a lot easier for us to pick up when a child is not well and they will accept that without any problems. Others I think see us as a threat.

From what was said it seemed that the attitudes of general practitioners towards Plunket nurses were becoming more sympathetic, more appreciative. It appeared that this change was initiated by the general practitioners, especially younger doctors, but it also seemed that some of the change could be traced to a changing Plunket nurse practice.

Robyn, in answering criticism directed at Plunket nurse practice, presented a picture of Plunket nurses intent on supporting rather than controlling parents:

> We're always being criticised that we don't have everyone under supervision, but that's quite normal really. People have the option. We are a voluntary agency. We can't spend all our time running around knocking on people's doors and threatening them. That's not how we work, but we do our best to visit people.

This is a picture of nurses developing a service which is more friendly, less cold and disapproving than previously, and therefore, far more likely to be acceptable to a wide range of people. Picking up the theme that Plunket nurses were now seen in a more positive light, Robyn said:

> I think it's changed greatly over the last ten years. For many years Plunket was always the poor cousin of the hospital or of the health system. It's greatly improved, greatly improved. In this area there is a terrific liaison with the paediatricians and the social workers and the Area Health Board and the public health nurses...I think we've improved our image greatly.

When Robyn added, "We don't really have any hassles here, but I know it's not the same everywhere else in New Zealand," she implied that Plunket nursing practice had changed more in some geographical areas than in others. Mary, who had had a more negative experience with other health workers, worked in a different district to Robyn. While the pace of change might be slower in some areas than in others, the overall result was that Plunket nurses were becoming more widely appreciated by other health workers.

Service Users

Do you believe that your perception of Plunket is shared by the people who use Plunket services?

The perceptions of those using Plunket nursing services were discussed at several points throughout the interviews. It emerged that the nurses had found that popular perceptions of Plunket were often at some distance from their own views. One of the major reasons for this dissonance appeared to be the changing nature of Plunket services. For example, nurses were required to reduce the number of consultations, both as home visits and as clinic appointments. Mary spoke about one result of the reduction in visits: "[people get] slacked off...because you are not visiting as often with their third baby as you did with their first." Plunket as a less controlling, less narrow and more flexible service appeared to be another factor. Philippa thought that the majority of people saw Plunket as "just a weighing service," and she added, "The way that you discuss the service that is offered with them helps them to see it more broadly."

New immigrants do not know about The Royal New Zealand Plunket Society, but further than that that some families within New Zealand do not have a tradition of using the Plunket nursing service. In the past, public health nurses have provided this kind of service in rural areas. Maori people, urban as well as rural, continued to choose public health nurse' support up until the early 1980s, when a change of policy transferred all infant welfare supervision to Plunket in most areas. Given Maori migration to the cities and the institutionalised racism which has pushed Maori into low income groupings, as well as the influx of new immigrants to urban areas, Plunket nurses now find themselves working in neighbourhoods where many residents are unfamiliar with their work. Fay described her experience:

> They were always happy to have you in the house but they...weren't too sure what you were offering...Certainly nobody knew who I was when I was driving up and down the street. But once you are known...then people would...pass things on word of mouth. So you just had to work very hard at getting to know them. They wont come to know you. If you work in another area people will very smartly

> come up to you in the clinic to get the advice or the help that they need, but here we have to build up credibility. That's not quite so hard now because they do know me now. They do come to see me.

From the above, it seemed that two factors influenced the perceptions of service users: first a changing service, so that people who were familiar with how it had been, now had unrealistic views of it; and second the presence of people who had never had any familiarity with the Plunket nursing service. In both cases, nurses were required to educate those who were using or could be using their services. In the first instance education would improve communication between nurse and service user. In the second instance, education would facilitate access to the service by those whose needs could be met by it.

Robyn and Wendy indicated that there was a need for more widespread education about the structure of Plunket. Robyn, talking about trying to increase awareness about the voluntary side of Plunket said, "...a lot of people just take us for granted." Wendy had similar concerns:

> I think Plunket probably should never have been a free service. I tend to think that most things that are given free are abused and I think that if everybody who came to Plunket paid, say 50c for each visit, they would probably respect Plunket quite a bit more. A lot of parents are very, very abusive of the system and abusive of the people who are offering the service, and yet they are contributing absolutely nothing towards it. They think that the nurses should just be there when they want to see them.

As she talked, however, Wendy too began to discuss education. She ended by saying, "I think a lot of the reason why Plunket has been abused is lack of education. The public just didn't understand."

Policy Makers

Do you believe that your perception of Plunket is shared by policy makers —within Plunket, within Government?

Fay's response to this question was, "I don't think they do. I don't think they do. I really don't think they do." There was general agreement that policy makers did not understand either the work of Plunket nurses or the situation of people trying to live on very low incomes in New Zealand. Comments from two different nurses captured the general feeling: "probably none of them have ever gone without a meal and are never likely to"; "[policy makers are] out of touch with what is happening at the grass roots level." There was an almost complete consensus on this issue. One nurse described policy makers within Plunket as being constrained by the level of Government funding,

while another pointed out that volunteers held a powerful position within Plunket, and that "they all came from one place" the middle and upper-middle class. The position of Plunket volunteers, their lack of front-line knowledge and experience, and the power that they held was a major issue. Beth said that in twelve years she had seen very little understanding shown by people making Plunket policy:

> There has never been a survey done that we have seen...How are we addressing the Maori needs? How are we addressing the Polynesian needs? There are a lot of refugee people out there. How are we really meeting those people's needs?

As she continued, she addressed the implications of the reductions that had been made on the number of Plunket nurse visits allowed per infant:

> ...it's fine for people who have a car and can get themselves to the Plunket nurse, but (not for) a person who is shy and has to learn everything new. You can only build up a rapport with people by stopping in and giving them some time...If you have only dropped in once or twice there's not much rapport. So the policy makers are making policies for a particular sector in our society but they haven't looked at it overall. I feel very strongly that we express that as a group; that of all of what we see, Maori health is the poorest in the country and we still have not addressed that issue...I think individual nurses try very hard... but I think there are many many young Maori people who we have not helped...Our Government and the Plunket Society have not really addressed issues relating to Maori health policy.

In Beth's experience policies addressing critical health issues were not in evidence. Fay, addressing the same issues, also emphasised the importance of building rapport:

> ...it has to be a one-to-one contact to build up a rapport, to get their respect. We as Plunket nurses need to learn a lot culturally, but that develops because you are working with people of different ethnic groups. I've learnt a lot from the people, not from the books or anywhere else...I don't understand everything but I do have a better understanding than I did before. Then when you start to talk about health nurses, you need a Maori health nurse, you need a Polynesian health nurse, an Asian health nurse, and so on. It gets quite complicated...But I really feel it has to be recognised that we can't have a universal policy, it has to be relative to the area.

In the above, Fay explained how she has gained a better understanding of how it is for people whose lives and culture are different from her own. In doing so, she indicates why it is that others, including many of those responsible for Plunket policies, do not 'see' or understand the needs of many of those using Plunket services. In order to gain this insight, it may not be necessary to be in exactly the same position as Plunket nurses, but it does require a willingness to listen and to learn. The idea of culturally safe nursing practice is inherent in much of what Beth and Fay have said. They are asking for policies, from decision makers within and outside of Plunket, that will improve the flexibility of the Plunket nursing service, so that it meets the diverse needs of all the people in Aotearoa-New Zealand.

SUMMARY AND DISCUSSION

The Plunket nurses in this study placed Plunket within the health system by describing the work that they did. They also described the importance of the Plunket nursing service in terms of its activities. Plunket nursing is characterised by multiple functions and roles performed in association with both individuals and groups, with particular emphasis on the well being of families. Plunket nurses are engaged at all levels of prevention, but their main focus is at the primary level (health promotion and health protection) and the first part of the secondary level (early diagnosis and early intervention) (Pender 1987:4-5). Plunket nursing is multi-faceted, reaching into and linking with other systems including other individual people who each represent their own multi-faceted system. Networking with other agencies and linking people together into mutual support groups was seen by the nurses as a major aspect of their place within the health system. They brought with them—as part of this awareness of links between agencies and between people using health services—a view of a flexible, comprehensive, dynamic system. It is not easy to chop up such a perspective into categories and still retain its complexity and vitality. Existing two-dimensional schema tend to distort and omit important features. Perhaps this is the reason why the nurses participating in this study found it so difficult to answer questions about the New Zealand health system and Plunket's place within it.

There was little variation in these nurses' views on their work, and they thought that most Plunket nurses were in agreement with them. Wendy suggested that individual difference explained any disagreement that does exist, while Fay stated that Plunket work must vary according to the social needs in each locality. Further than that, in the past, Plunket nurses have tended to work in isolation from each other, and thus have had little opportunity to discuss their views and reach consensus. This was true for some of the nurses in this study. Others were working very closely with their colleagues, co-operating together to run group clinics in pre-schools for example (Chapter 9).

It was generally acknowledged that some health workers were in agreement with Plunket nurses over the nature of Plunket work, and that those whose work was closest to Plunket nursing had the best understanding of this work. Overall the attitudes of other health workers towards Plunket nurses were seen to be improving. There was also agreement that many of the people using Plunket services did not fully understand the breadth of the service offered. There appeared to be two main reasons for this: the practice of Plunket nurses was changing; and recent immigrants and Maori people were unfamiliar with Plunket. The constraint of trying to work with people who do not understand the full extent of the service offered will be addressed further in Chapter 8,

and the changing nature of Plunket work, and changing attitudes towards Plunket nurses will be taken up in Chapter 9.

On the whole, it was felt that policy makers did not understand what was involved in Plunket nursing, and there was seen to be a particular urgency for policy makers to address Maori needs. Given the reductions made to the number of home visits required per infant, comments about the necessity for continued home visiting can also be interpreted as a critique of the understanding of policy makers. As with any outsiders, it is difficult for the people making policy for The Royal New Zealand Plunket to see how crucial home visiting can be to the successful outcome of a Plunket nurse's work. According to Salmond (1975:76): "Evidence from overseas studies supports the view that poor mothers communicate most effectively in their own homes." This supports the argument that the information gathered while visiting people at home is crucial to gaining a sound understanding of the circumstances of each family situation, and thus to building the relationship of trust that is essential in the work that these nurses do.

Part Four: The Work

CHAPTER 7

NURSES' WORK: IDEAL RELATIONSHIP AND GOALS

In the early 1980s, Ferguson (1982) argued that there was a transformation occurring within Western medicine. This transformation was centred partly on vision and partly on the quality of the relationship between health service provider and health service user. Ferguson (1982:270) maintained that one of the assumptions of the "new paradigm of health" was that "[the health] professional's caring was a component of healing." From my own experience, I had found that this was so. I had learned to see the quality of relationships, within a health system, as critical to the quality of practice and to a more positive outcome for that practice.

The changes, as noted by Ferguson, also mirrored what I thought was happening within the Plunket nursing service. Namely, that with increasing frequency Plunket nurses were working towards establishing I-Thou relationships (Buber 1958) with the people using their services. This observation was one of the reasons why I chose to do this particular study. Consequently, I was concerned to discover the views about ideal relationships of those who participated. Questions on goals when working with families, with other health workers, and as community nurses, served as a back-up to those on relationship. Therefore, responses to these questions about relationships and goals are integrated into one chapter.

Drawing on the nurses' ideas about ideal relationships and their work related goals I will present sections on these topics in relation to family and community. Then I will present the nurses' views on ideal relationships and goals with other health workers. This latter section will end with a discussion of what was said about the relationship between Plunket nurses and Plunket volunteers.

RELATIONSHIPS AND GOALS WITH FAMILY AND COMMUNITY

In this section, I will focus first on the nurses' views on the ideal relationship between a Plunket nurse and a parent using Plunket services, and then on the nurses' goals when working with a family. Since responses to these questions were repetitive, I will present the latter as a summary, which will also act to draw together the main points of the former section. Finally, I will discuss the nurses' goals when working at the community level.

Relationships At Family Level

In your opinion, what would be the ideal relationship between a Plunket nurse and a parent?

When asked about ideal relationships, the pattern with other questions was repeated. It eventuated that many of these nurses had not thought about relationships in an abstract way, but were accustomed to dealing with a more material world. For example, when I asked Lynn if she had ever thought about the ideal relationship between a Plunket nurse and a parent, she replied, "Not quite in those terms," and Susan said, "Oh, I've never come across an ideal relationship."

However, in actuality the nurses were thinking constantly about the nature of the relationships that they experienced with others. Throughout the interviews they all expressed the same concerns over the quality of relationships. For example, they all expressed an interest in finding the delicate balance between closeness with families and maintaining professional integrity. This theme surfaced again and again and was related to themes of domination, control and dependency. How they viewed their relationships with people using their services was apparent long before questions about ideal relationships were addressed. For example, early in the interview, when she was talking about the importance of Plunket, Trish said, "We are just trying to help them help themselves. It is important not to be too domineering. That takes the decision making away from them." These last two sentences clearly indicate an awareness of the danger of creating dependency, an awareness that permeated one interview after another.

It seemed that dependency was associated with social hierarchies. None of the nurses expressed approval of social hierarchies, and though they did not discuss in detail how a social hierarchy might expedite dependency, this causal association was implicit in what they said. The following anecdote from Kate serves as an illustration:

> We've got a video here. It's called *Danger Signs,* and the mothers laugh at it when they see it. The doctor is telling a mother what danger signs to look for and she's saying "Yes Doctor. Yes Doctor." It just sounds so terrible. **I would like to see client and nurse on an equal footing** (emphasis added).

According to Kate, mothers, when they see this video reacted unfavourably both to the doctor adopting a dominating one-up stance and to the compliant mother. These reactions and the attitude of the nurse (Kate) demonstrated an acute awareness of the influence of social hierarchies on the people within them. Philippa depicted a parent who diverged markedly from the role of a compliant mother, when she said that an ideal relationship occurred: "Where the parent is taking responsibility for the health of the child [and] not just putting the responsibility back on the Plunket nurse or the general

practitioner or whoever else is involved in the area of that child's health." This parent would not automatically take a submissive role in a hierarchical health system. He or she would expect to actively participate. All of the nurses showed an awareness of the dangers of **creating** dependency by habitually taking a one-up position with the families they were visiting. Beth summed up the problem succinctly by saying, "The relationship that I like to work with is one where people are on the same level as me."

Without exception, the nurses also showed concern about **encouraging** families to depend on them because of their own need to be needed and liked. In such situations, relationships can become too close and too familiar for the nurse to continue to be helpful. This concern underlies Lynn's statement that:

> It has to be a professional nurse/client relationship. I have seen people try to make a friend of a client which I think creates some difficulties.... It's really so that the client respects your advice. There's an element of friendship but there's also an element of trust. I'm thinking of the situations where you've got a Plunket nurse and a client who's become very dependent on her. I think the Plunket nurse wants be able to have a relationship that has good rapport but at the same time it's not too close. This allows the nurse to be effective in what she is doing.

I checked with Lynn that she was talking about the danger of a nurse encouraging dependency in order to meet her own needs:

> That's right. ...but there's got to be balance. You can't be too far the other way. There's a variety of ways that health professionals relate to clients. The ones that I see as bad are the ones where it's too close a relationship. ...I guess in a way it's like when the family doctor is like a family friend. A family member needs to have someone else because they want someone who is just that little bit distant; someone who doesn't know every single last detail about them. Then there's the other end of the scale where the professional person treats the client as a non-entity. Where they don't know what the doctor is talking about. The professional person doesn't treat the client as having any knowledge. There's a lack of respect and trust (in that relationship).

"There's got to be balance." Like Lynn, the other nurses were continually weighing up the nature of their relationship with service users. Where do I draw the line between being a friend and representing a profession? How do I avoid taking a one-up position as a health professional? How do I avoid encouraging people to be dependent on me? Conversely, how to help people to be more independent was of major concern. Participants pointed out, like Fay for example, how they tried to help people to feel better about themselves, to feel more confident in making decisions: "It's building their confidence in being a parent...so that they can do it for themselves. I don't want to build a relationship where they are going to be running to me all the time and asking me [what to do]." Wendy spoke about her work as "basic":

> It's just having the client know that you have got a little bit of knowledge and that you are very happy to give them what knowledge you have without dictating to them...You are there to offer alternatives to what they are doing without encroaching on their private lives.

> ...There's not just one way of doing things, there's many ways of doing things. I always say to people that their new baby belongs to them—those two parents—and that the baby has to live in that household and that environment...We're not the experts on their situation. No, we are just there to offer alternatives if they find what they're doing isn't working.

One part of the dependent/independent dilemma occurs when a health professional assumes an authoritarian stance and thus takes the initiative from the other person. In this situation, the 'solution' becomes the service provider's solution, which is, even when also the preferred solution of the service user, imposed from above. A second part to this dilemma is that the ability for critical reflection tends to decrease as emotional involvement increases. Although none of the nurses spoke about 'critical reflection,' this seemed to be in their minds when they talked about the need to keep some distance between themselves and the people using their services. In order to keep a clear head it is important to retain some emotional detachment, but not too much.

Mutual respect was a necessary condition of the ideal relationship. This became apparent as they talked about empowerment, about helping parents to be more sure of themselves, to be more confident in their practise, to become more skilled and to have increased choice. Mary traced the process of crediting parents with the best intentions, of reinforcing parental self-respect and of sharing information; a process which leads to further options for those participating:

> I believe that every family is doing the best within their ability for their child. They really might be doing a lousy job, but within their life experience they're doing the best they can. I don't think I've ever, ever struck one that is not doing what they thought was the best. I think the most important thing is helping to build their self esteem and giving them knowledge when they need it.

Mutual respect was also basic to ideas about reciprocity and two-way communication. Ideas about reciprocity inferred that nurse and parent interacted on the same level. Kate, for instance, talked about parent and nurse gaining from each other:

> I may have the expertise on some of these matters but they have got many other things in which they are a greater expert than I am. This is just one area that I may know more than them, but surprisingly enough there are times when they tell me things and I think "Well, that's wise, I never thought of that." I've got nursing knowledge I can impart, but actual parenting they can leave me for dead sometimes. ...So I feel it's equality that would be the ideal relationship between a Plunket nurse and a parent.

Philippa summed up the "ideal relationship" as "an absolutely two-way relationship," a partnership directed "towards the health and well-being of the child."

The foundation for such a relationship can be detected in Kate's statement above. Humility, respect and trust underlie much of what was said, and may be necessary conditions of equality. Equality demands that a nurse respects the people with whom s/he works and also demands that s/he is sufficiently humble to openly acknowledge,

like Kate, that s/he can "learn from them." The nurses spoke with gratitude about what they learnt from the families with whom they worked. Fay, for instance, noting the health profession's former advocacy of putting infants to bed on their abdomens (a practice which has become associated with cot deaths), questioned whether health professionals could always claim to be correct. She stressed her appreciation of what she was learning from those using her services: "We're not always right, and so we have to be open...There are a lot of very valuable things that you can learn from them."

Talking about the importance of understanding the customs and beliefs of the people she was trying to help, Kate said, "It certainly doesn't pay to be judgemental." Sensitivity to social difference was one of the major themes threaded throughout the interviews. **All** stressed the importance of sensitivity. That a Plunket nurse recognise different needs and adapt his or her approach accordingly was seen as essential. Hope recognised that what was right for one person might be quite different to what was right for somebody else: "Finding out...what's best for them in their situation, ...Somebody else might live right next door, but they might be quite different. It has to be what's right for them and their family and culture." Hope connected insensitivity with taking a one-up position when she said, "I don't like that stroppy [attitude that], 'You must do it this way!' Every situation is quite different. I think you have to take every situation into account." Lynn, similarly, talked about the need for flexibility in a nurses' approach:

> ...with different clients there will be different types of relationships depending on the clients personal experience. There will be a very different type of relationship with a seventeen year old girl living in a flat with three or four other young people compared with a university lecturer...It's the same with cultural differences too. (You have) to be able to listen to what they're saying and work in with the way they do things.

Being able to see through others' eyes was implicit in the nurses ideas about sensitivity to difference. Wendy articulated this: "They give you a lot of confidential information that allows you to form a picture of what is going on in that family and that's...really important." 'How I perceive them,' and, 'how they perceive me,' were important ingredients in the process of developing mutual trust, and consequently, in the free sharing of information. Sensitivity and being able to see different points of view were the prerequisites. Like Wendy, all the nurses stressed the importance of building trust:

> How they perceive you is (going to influence) how much they're going to tell you, and if you haven't got that comfortable relationship with your clients you are not going to be any help to them. They've got to feel that what they are telling you is not going any further than the piece of paper you have written it on or ... those four walls; and that in the future if they've got a problem that they can come and ask you and know that it is going to be confidential.

The importance of home-visiting in establishing a relationship with a family re-emerged. I am sure that all of the nurses interviewed would be in agreement with what Wendy said:

> How you approach that person and how they encompass you after you have gone into their house is probably going to be the crux of the whole relationship between you and the client for the rest of the time that you see them...To me it is really important that when you go into that house you treat it as though you are actually a guest in that house. You have no right other than the fact that you are there as their guest. You want them to feel comfortable in your company and you want to be comfortable in theirs.

Non-intrusiveness was stressed by these nurses. They saw the didactic approach by a health professional, who placed him or herself one-up in relation to someone using health services, as presumptuous, even invasive. This was not their choice of approach. Rather they chose to listen, to affirm, to offer choices in order to broaden horizons. These were major recurring themes, and nothing was possible without mutual trust and respect.

Goals at Family Level

What are your goals when you are working with a family?

When I asked these nurses about their goals, they told me that they endeavoured to develop ideal relationships with the people with whom they worked and to help parents to be more self reliant. For instance, Kate said, "My goal in the end is to help clients towards independent thinking; to empower people to take care of their own health; to have faith in their own decisions." In other words, responses from one section of the interview overlapped with those from another, resulting in a marked degree of repetitiveness. Rather than repeat in detail what has already appeared in previous chapters, I will present a summary of goals when working with families. This will also act as a recap of what was said about ideal relationships with parents.

With respect to goals when working with parents, the nurses stated that they worked towards establishing relationships based on the principles of trust, respect, reciprocity; relationships in which all who participate are enriched. When talking about goals for their work with infants they repeated what they had said previously about the value of Plunket (Chapter 6). Philippa, summing up, stated that her goals were: "To maintain the health of infants, the safety of infants, and the health and well-being of the mother or the caregiver." Philippa also drew attention to a nurse's responsibility to update her own knowledge: "...so that I can give people information that is going to help them make good health choices, and to maintain a working network of other services that the

family might want to use, but has no knowledge of." They therefore worked towards increasing confidence and enhancing choices for family members, and they stressed the importance of cultural sensitivity, of treating each family as uniquely different.

Goals at Community Level

Do you have any goals for your work at community level?

Although all of the nurses mentioned sensitivity towards cultural differences there seemed to be different levels of awareness. A continuum in levels of awareness became more apparent when they discussed their practice as community nurses. In the following paragraphs I will trace this continuum choosing responses which typify different places upon it, beginning with responses that showed the least awareness.

When I broached the subject of their work in the community they often asserted that they were family nurses, but as I continued to question them they recognised themselves as community nurses also. Fay, for example, replied:

> ...Within the community? Not really. I work with families...I mean if they want me to speak, I'm happy do that. There's a church that I go along to and do health talks, so in that sense I do, but that's about as far as it goes. I am not involved in any political way—but in a sense it's community work that I am doing.

While Fay was available within that community to talk on health related topics, other nurses had other kinds of community involvement: offering parenting courses and courses on child development and child care, participating with other health workers in running joint clinics, involvement in pre-schools of various kinds and helping to ensure that parents were aware of what pre-school opportunities were available for their children. Beth had established and still ran a play group on one of her day's off. The fact that it took some of them a while to recognise that they were community as well as family nurses suggests that full-time Plunket nurses require space in their working day to reflect on their work. Noreen articulated this:

> From time to time I try to re motivate myself, which you have to...otherwise you just go downhill and never come back up again. We don't have enough time for ourselves to sit back and look at what we're doing and how we're doing it and if we should change things... I think that built into our job description (there) should be planning time...reading time, so that we can keep up to date.

Mary showed more awareness of the potential for community work as she described her reactions to her first year on the job:

> I think I was just beginning to see the scope of Plunket. How you could get things going in the community... I wrote down the goals that I wanted to see achieved

> in the area that I was working in. Goals like getting a playgroup going in a housing area that had a lot of migrant women living in it.

Susan and Beth were also fully aware of the potential for Plunket nurses to work at community level. Beth had pre-school supervisor qualifications, and had begun to run a playgroup in her own time. This group met one day a week in a school classroom, well equipped with play materials. Beth was not in full-time paid employment and did not have as many demands at home as many of the other nurses participating in this study. She had time for reflection and her number of paid working hours left her with some energy for other activities:

> My personal goal is to help people as much as I can. Through the playgroup I am providing people with more than just a little bit of input. I am actually helping these people take some major steps in their own development and to become interested in parent education. One Samoan woman who would sit there and say nothing, now is taking an active part, and she is asking what she can do for herself (in order to learn more). People are actually becoming aware that there is a lot more that they can help their kids with than they have ever thought they could. To me that is one of my goals... to help people to build up confidence and to help them to do as much for their children as they can, to start looking not just from day to day, but to start looking ahead in their own lives.

When Beth talked of running the playgroup two days a week. I asked her if she would go each day. She replied:

> I have no intention (of doing that). I think that that would be going too far. ...You have to teach them the skills, but then you also have to stand back and let them do it for themselves. Otherwise I just do it for them and that is not what it is about.

Beth involved the mothers attending the playgroup in planning an educational programme for themselves. One indicator of the success of this programme was provided by Beth when she talked about the reaction of a psychologist who had been invited to visit the play group regularly:

> ...he says it's a completely different group. "The people," he said, "They look a lot happier and they are much more involved with the children." To me that's a goal I would like to see go a little bit further, so that the mothers are going to take responsibility themselves for the group. They now have agreed to monthly meetings which we never had. For so many of them to go out for one night a month, just to do something like that, is a big step.

It seemed that these nurses did display different levels of awareness, but all were moving in the same direction along the same continuum. They were moving towards helping to increase autonomy, competency and well-being for family members within Aotearoa/New Zealand. If this movement requires that these nurses become community as well as family nurses, then this is what they will become. In fact, this is what they were becoming.

IDEAL RELATIONSHIPS BETWEEN PLUNKET NURSES AND OTHER HEALTH WORKERS

There has been a tendency for paid health workers (health professionals) to see themselves as having more status than those who are unpaid, and there is a strong tendency also for people to arrange themselves into inter- and intra-professional social hierarchies with, for example, doctors holding more status and power and earning more money than nurses. I found, as a practising public health nurse, that I often had to work very hard to establish credibility with other health professionals, who saw themselves as being placed above me on this hierarchy. While this experience was not universal, it did include some health professionals from a number of different occupations, including social workers, psychologists, general practitioners, and on one occasion, a physiotherapist. It seemed that nurses were perceived to be close to the bottom of biomedical hierarchies. Accordingly, I wanted to clarify where the nurses participating in this study put themselves, and to clarify whether or not they saw their status within such a hierarchy as influencing their behaviour towards others.

Health Professionals

In your opinion what would be the ideal relationship between a Plunket nurse and another health professional?

Nurses took this opportunity to indicate that relationships with other professional health workers were less than perfect. Both Lynn and Mary introduced the concept of 'equality,' the latter stating that the ideal relationship with other health professionals would probably:

> ...be as equals—an appreciation and an esteem for each other. That's ideal, but in reality I don't believe it is like that. The ideal situation is to be supportive to each other. Sometimes it's one-way with us giving out information, but that's not reciprocated.

As mentioned in Chapter 6, the nurses did not see their relationships with medical practitioners as particularly problematic. Each had established satisfactory working relationships with some members of the medical profession. Some reported better relationships with younger rather than older doctors. Wendy indicated that relationships with doctors were improving:

> I don't think they (general practitioners) see us as quite the threat that they used to...I think probably the biggest problem between Plunket nurses and doctors was that the doctors felt that we were encroaching; that we were actually diagnosing and sending somebody along already diagnosed, and they did not like that.

Wendy had found that by re-phrasing her concerns, so that they sounded like a request for help rather than a diagnosis helped. She added, "Then they don't think you have pre-empted them."

Occasionally during an interview, problems relating to respect for the privacy of others was discussed. The hospital grapevine is famous. A not-so-famous grapevine also exists amongst health workers outside of hospital. Hope talked about confidentiality in connection with developing an ideal relationship with other paid health workers:

> Listening to each person's point of view in total confidentiality. That's the thing that bothers me... I feel quite protective... of the clients. Often I would like to ask somebody (another worker) something or other but I feel too cautious to give a person's name away. I ask a lot of questions without using names.

Despite the hierarchical social structures they worked within, ideal relationships were seen in the same terms regardless of the status of the other person. Thus responses about ideal relationships with other paid health workers were repetitive of responses about ideal relationships with those using Plunket nursing services. Lynn spoke to this point: "I think they're the same [as that between a nurse and a person using the services]—an equal relationship." Listening, respect, learning from the other, acceptance of different ideas, understanding each others' position, reciprocity, confidentiality, equality—all of these were mentioned.

The nurses were also asked about their goals when working with other health workers. These goals were so consistent with their views on ideal relationships that a detailed presentation would be mere repetition. Briefly, they said that their aim was to work co-operatively with others, to build networks, and to avoid overlapping services. They worked towards relationships that were reciprocal and egalitarian, based on mutual respect. This was regardless of the other worker's status, paid or unpaid.

Unpaid Health Workers

In your opinion what would be the ideal relationship between a Plunket nurse and an unpaid health worker ?

When the nurses discussed their views concerning an ideal relationship with unpaid health workers they talked of co-operation, understanding and mutual respect, as they had in relation to paid health workers. Again, there seems little point in repeating in detail what has already been presented above. Fay's response was typical, "With volunteer health workers it's the same as with health professionals, easy communication and sharing."

However when asked about unpaid workers, Philippa said, "Have you found with Plunket nurses that immediately you say 'unpaid' they think of Plunket volunteers which acts as a barrier to all the others?" This is exactly what had happened. One nurse, for example, on hearing the question, declared that she had "a lot to say about Plunket volunteers," and asked: "Is this the appropriate place?" It could be imagined that the most important relationship with other health workers for these nurses would be that of Plunket nurse and general practitioner, but as they talked the relationship between Plunket nurses and Plunket volunteers emerged as most significant. Therefore, I have concluded this chapter with an examination of their responses about this relationship.

The Relationship between Plunket Nurses and Plunket Volunteers

The words 'unpaid' and 'volunteer' evoked an immediate response about the volunteer side of Plunket from nearly all the respondents. Relationships with their volunteer committees emerged as one of the most critical relationships in their work environment. Because of the way in which the interview topics were ordered, the nurses had been talking about working with a number of different people on an **equal** basis before the question about working with unpaid Plunket workers came up. Several times, the words 'volunteer' or 'unpaid workers' evoked embarrassment and ironical laughter. Kate, for example, said: "Now this is different [laughter]. This is quite funny isn't it? And that really cuts down what I've just said. No we'd be—I feel [laughter]—that's so funny, that question coming up. No. I feel that we are equal really."

Many of the nurses were uncomfortable as they talked about their relationship with their Plunket committee, but they **all** emphasised the dedication of Plunket committee members, and showed an awareness and appreciation of the difficulty and importance of the work of their committees. Lynn spoke for the others when she said, "They work incredibly hard, and most of them have pre-school children. It's important that we do support and acknowledge what they do." Noreen was explicit in her appreciation of the work of her committee:

> There have been a lot of hassles. They've (the volunteer committee) persevered. It took them eight years to get the new Plunket rooms even though they don't own them. They have done very well. Over all they would do anything for me, get anything for me, I've only got to ask...I've got very nice working conditions. I must tell you that.

The nurses' also appreciated that their Plunket committee members were experiencing stress because of rapid social change inside and outside of the Plunket organisation. Lynn pointed this out and so did Mary, who said, "They're finding the changes just as difficult as the nurses are."

While the nurses evinced insight into the situations faced by Plunket volunteers, they also perceived that there was conflict between nurses and volunteers. The power structures within Plunket were seen as a cause of these difficulties. One nurse talked about going to a branch meeting when she was a student, "There's only one nurse to about forty women, and they attack the nurse. I perceive that they do...I felt 'The poor nurse.'" Another said that she felt that she was treated like a servant by her committee members, while Mary had the following to say:

> The volunteers seem to have more power than the nurses do and that's really hard to live with. It's power within committees and power money wise...Perhaps because they don't actually pay your salary, but because the money they raise is to pay the expenses of the clinic...You are under obligation to them. It's not spoken, but it's very powerful.

Robyn's statement about the Plunket committee holding the purse supported Mary (previous quote):

> The difficult part about it is actually asking them for everything. We have to ask the volunteers when we want to buy things. And then you've got to think that that money comes out of a big percentage of their pockets and their husband's pockets. It's a very difficult thing to do and that's why a lot of nurses don't like tolerating it. And therefore you learn to run the system on a shoe string really. ...Well they (the nurses) grumble about it all the time, "Why should we have to do it?" If we want to have a lot of education—extra education—we either have to fork out and pay for it ourselves, or try and persuade the committees to put the money up. And the committees are made of upper-middle class/upper class people who now don't have a lot of money in their pockets like they used to...All the time you're very conscious about money...Well I am, because I've been in it a long time...And I've been a volunteer for six years.

Here, Robyn indicated that part of the difficulty in asking volunteers for money arises from a nurses' awareness and sensitivity over the cost to volunteers in raising the money in the first place.

Plunket nurses' attitudes towards volunteers were mentioned. One nurse said that she felt uncomfortable with the way colleagues talked about Plunket volunteers, and another recommended that nurses should not take "too high a professional attitude with volunteers...You have got to work in with them and I think you've got to help them as well. If you help them they will help you." Trish, who worked with her committee to help them sort out internal conflicts, would agree with this. She began by commenting on the pecking order within a Plunket committee, "I'm amazed at how disloyal they can be to each other. They really hurt each other...The volunteers are supposed to be helping us, but I find I help them more than they help me." Like Trish, Mary had observed conflict within a particular Plunket committee, "There's some power things going on in the committee which makes communicating with one member of the committee, or the whole committee, difficult." Hope presented both sides of the equation:

> I think it all depends too on what pressure you put on them, and the attitude and the way you speak to them. You've still got mothers out there who want to go on a local committee, who really want to help the nurse as much as they can, but the politics of the voluntary side is really bad news. It has caused trouble and has left a really bad taste.

One of the major difficulties experienced with committee members related to a lack of mutual understanding. One nurse said, "I don't think they seriously understand what the job is. They don't see what we see." The 'not seeing' theme appeared to be two-way. Several of the nurses had also spent time as Plunket volunteers and could speak from a volunteer standpoint more readily than those without this experience. Nevertheless, the nurses did see the ideal relationship with a Plunket volunteer in the same way as they saw ideal relationships with service' users and with other health workers. Philippa said: "I think there is a two way partnership where you both have a clear understanding of one another's roles and how you can both help each other to fulfil those roles at that local level." There was total agreement on this, and while some nurses for a variety of reasons had not achieved this kind of relationship with their committees, others were more satisfied.

When the improvement of Plunket nurse/Plunket volunteer relationships was discussed, positive feedback was seen as important. Mary, for example, said that she admired her committee "immensely" and let them know that she did. Hope described the care she took not to over-work her committee members: "I like there to be a large amount of people... so that not everything has to fall on a few. ...They're busy, busy mothers."

Overall the nurses described their relationships with committee members as improving, especially as the composition changed to include more parents with whom they had worked. One who had previously enjoyed such a situation, had recently moved to a new work place and hence a new committee:

> I'm looking forward to having my own committee. I haven't been here long enough (yet). I'm looking forward to having a president who has been a client of mine with a baby...We haven't got the same relationship that there'd be with a mother who I had visited. See the relationship I had with my committee and with my presidents where I worked before was different altogether. We became friends as it were and they'd pop in and we'd discuss whatever. Whereas now I get phone calls, an occasional pop-in maybe, but it's not the same. It's not the same closeness.

Hope, who had recruited most of her committee, talked of their excellence: "We've got a really good committee here...really neat ladies." Committee members who were accustomed to the practice of 'their' nurse acted as a boon to the relationship between nurse and volunteer committee.

In areas where most people are existing on low incomes, asking someone to go on a fund-raising committee is not easy. Beth talked about her reaction to working with a committee in such an area:

> I found it really difficult to go to that committee and see these women having to raise money. I really felt that that was the last thing that they wanted to do; that there was nothing there that could benefit those mothers... Nothing for personal growth, but only money raising. I just couldn't believe that a Society that is working for them could be like that...Fund-raising has become important out of all proportion.

Beth suggested that if committee members received support and education the above situation would not arise, and that Plunket volunteers given the right sort of assistance could very usefully complement a Plunket nurse in her work.

Being a Plunket volunteer was seen as one avenue by which women in unpaid employment at home could move into a more public world. Nurses who had worked on Plunket committees had insider knowledge. Susan was one who spoke eloquently from personal experience:

> It first started I think when I just sort of got out of the four children phase...I was asked by a friend... if I would come along to a committee meeting. I wasn't assertive, I was a bit of a mouse. I didn't like going to meetings...but I said I would and I went along and I ended up as part of the committee and doing catering...Oh, it was wonderful!....You'd been (at home) all week...and there's not very much feedback at that stage with the children, and then suddenly your husband's home and you're saying "I must go and do my Plunket work." It was lovely. It was a good excuse.
> ...We'd meet all the other women and we'd be peeling potatoes and cooking. We worked damn hard. It was superb. We felt really uplifted. We weren't just sitting in a committee . We were actually in there doing things which mothers are good at because they're doing it everyday, and we made money for the Plunket Society. Because you were making money for the rooms, maybe to put new curtains up, maybe to put a fence up for safety, maybe to provide the car for the nurse, you felt as if you were doing a worthwhile job. It was coming back into the community.

An egalitarian relationship was with volunteer committees was seen as ideal. Some nurses had managed to achieve this, but it was not easy even for those who had been Plunket volunteers, as Robyn had: "It's difficult—difficult working with the volunteers and working on the professional side too. It's totally different. It's quite a challenge." Several factors work against a nurse and a volunteer working in harmony. These factors include the structural separation of nurse and volunteer hierarchies, and their different responsibilities. This separation and difference leads to a difference in experience, in perception and in goals. Conflict between the goal of making ends meet and that of running a health service was of major concern. I felt that Kate spoke for all of the nurses when she said:

> ...we need respect on both sides. We are the people that deal with professional matters. They are possibly the experts on the business side but they have to listen

> to what we say professionally. They can't just arrange the management of the money as they see it without knowing what the professional idea is, what the client's need is.

SUMMARY AND DISCUSSION

Consistency of response was highly noticeable. Variations in viewpoint appeared as variations on a theme. When the nurses talked about the ideal relationship between themselves and other health workers, both paid and unpaid, they were in very close agreement, and this was also true of their stated goals. This consistency of response lead to a great deal of repetition, hence some sections of the interviews have been presented in summary in this chapter.

As with other parts of the interview, it became apparent that many of the nurses had not given much prior thought to the questions with which they were faced. For example, some had not thought about themselves as community nurses or about relationship in an abstract way. Nevertheless, when faced with these questions they demonstrated that they were thinking critically about the quality of their actual relationship with both the people using their services and other health workers. An ideal relationship for these nurses was a reciprocal relationship, based on trust and mutual respect. They were working to establish I-Thou relationships (Buber 1958) and aiming to work in a mode consistent with Ferguson's (1982) description of the 'new health paradigm.' Furthermore, their work was based on principles similar to those attributed to Freire (Alschuler 1986). These are the principles of humility, faith, hope, love and trust, and it seems that the continuum of awareness revealed in the nurses' responses, is related to the sixth principle, that of critical thinking. To think critically, however, requires time for reflection—something many of these nurses lack. Even so the nature of relationship was receiving a great deal of their attention.

The relationship that Plunket nurses have with Plunket volunteers appeared as one of their most significant and problematic relationships. What was said about this relationship supports Norton's (1990:163) finding: "The relationship between Plunket nurses and Plunket Society volunteers...needs to be evaluated at an individual level and an organisational level." Those who had themselves worked as volunteers were able to see both points of view; volunteer and Plunket nurse. Also, remembering to give volunteer committees positive feedback helped the relationship and committee members who had come to know a nurse through using her services were understanding and supportive.

In the introduction to this chapter I noted that Ferguson (1982) also included a changing vision as part of the transformation that she saw occurring within Western

health systems. This change was from a narrow view represented by the medical model (Chapter 1) towards a more holistic approach. A broadening vision has been implicit in much of what these nurses have said (recorded in both this and previous chapters). From their responses, it is clear that they were prepared to both accommodate and learn from a variety of health practices. As they sought to understand how the people using their services view health they themselves experienced an ever expanding viewpoint. They talked about sensitivity towards others, about flexibility, about being non-judgemental. These terms relate to both vision and relationship. How these nurses see their work in the context of health is intimately connected to the quality of relationship that they endeavour to achieve with all of those with whom they work.

The almost continual discussion throughout the interviews of striving for balance between being involved but not too involved appeared like a search for the term 'disinterested love.' Lumby (1993c:10-11) could have been thinking of any one of these nurses when she recited that the voice of a nurse is: "...the voice of caring, equity, cooperation and empowerment not of 'detached observer.'" From their accounts, these nurses were working in a collaborative, cooperative and caring way in accord with a broad vision of health.

CHAPTER 8

NURSES' WORK: REWARDS, CONSTRAINTS AND SUPPORT

While working as a public health nurse (1979-1985), I found that a number of factors acted against my achieving my goals. I also found that support for what I was trying to achieve and for my particular style of practice came from a variety of sources. During that time I read *The Aquarian Conspiracy* (Ferguson 1982), and found that my mode of practice was closer to that attributed to 'the new paradigm of health' than to 'the old paradigm of medicine.' There was a commitment to advocacy for those using health services inherent in this 'new' paradigm. Albee (1980:100-101) noted that anyone working in any of the social services is faced with conflict associated with allegiance, responsibility and accountability. He argued:

> The fundamental professional decision is whether we represent the client or whether we represent the agency, institution, and society that pays the salary. ...The professional must continuously decide whether he or she is a defender of the established order or must become an advocate for the victims of the established order.

He maintained that those who put service users first can themselves become labelled and ostracised. He continued, "We need unanimity in these matters, or we will be picked off one by one!"

As a result of my own experience, I was interested in what Plunket nurses found rewarding, what they saw as constraints on their practice, and where they found support. This interest has been heightened by Albee's comments, together with the nurses' strong emphasis on support and empowerment for those using their services. I will begin with the positive—the rewards. This serves to re-establish the value that these nurses placed on the people using their services. This is followed by sections on constraints and personal costs, and an appraisal of where participants found support for themselves and their mode of practice.

THE REWARDS

Do you find Plunket nursing personally rewarding? If so, in what ways is it rewarding?

The immediacy in the reactions to this question spoke for the nurses' certainty about what was rewarding for them. Furthermore, what was found to be rewarding was congruent with their motivation for working as Plunket nurses (Chapter 3), the value of

Plunket (Chapter 6), work-related goals and views on ideal relationships (Chapter 7). It would be extremely repetitive to repeat here what has already been presented in earlier chapters. Hence, the following quotes offer typical examples of what was rewarding:

> You see change over a period of time. You build relationships with people. You sense a trust developing. —Mary

> Being able to problem solve. To help somebody find the right avenues where they can get help. It may be from me directly, or it may be steering them in the right direction. —Hope

> I think it's seeing mothers just letting us go and developing on their own. —Kate

These three quotes reflect the process that had already emerged. Namely, building a relationship, developing trust, referring on when appropriate, and seeing people become more self-reliant. Rewards came from seeing positive outcomes to their work. As Susan put it:

> I get a reward out of helping other women—very much so...by teaching them to value themselves...If somebody has problems about their own personality or the feelings that they have of themselves, that's going to go right through the family and in the end into the community ...If you look at it from a higher point of view, (we are) raising the level of community health and the health standards of New Zealand, so that we can once again raise our heads throughout the world.

In a sense they were working themselves out of a job. But the work and its effects were almost invisible, and therefore the rewards proved to be elusive. Fay saw changes in behaviour occurring over time: "People who never say a word start to ask you things...They're [no longer] shy and frightened. They're asking good questions. That's really rewarding." Noreen, acknowledging that the changes she was initiating were difficult to see, said, "Sometimes it takes a while to realise that your input has had a long term benefit." Philippa, in listing these more intangible changes, articulated again the goal of helping people to become more self-sufficient.

> It was the little intangible things. Seeing perhaps their health practices change for the better, or seeing a woman's self esteem begin to improve, or seeing someone have a little bit more knowledge because it is something you have taught them and then being able to implement that in their own way with their child. Those things I found **really** rewarding.

Mary talked about making the positive outcomes of her work more visible: "I set myself little goals to show I am getting there...open clinics—if they trust you, they'll come and they're prepared to wait." Although Plunket nurses, as Mary indicated, need to work at recognising positive feedback, some outcomes are more obvious. Lynn and Philippa, for example, noted the reward of identifying a problem early in a child's life and ensuring that appropriate intervention occurred. Fay talked more broadly about the satisfaction of working to promote health: "I'm glad I made that move [to Plunket]. It

was something I always intended to do. I felt strongly towards a wellness and primary health care approach, and I see Plunket as that."

Beth and Wendy also talked about the pure enjoyment of the work itself. Wendy said, "I enjoy Plunket nursing. I enjoy meeting the people. I enjoy feeling that I've been supportive and helpful." These rewards are what a psychologist might label as "intrinsic" (Chaplin 1968:251): the activity is found to be interesting and rewarding in itself. Within the process of assisting people to positions of greater strength there were personal gains for the nurses, but these also were not extrinsic. In order to meet their goals participants were challenged, and in order to meet the challenge they resorted to further education for themselves (Chapter 4).

As well as the extra courses that they took, they learnt on the job. Susan looked at the gains she saw herself as making through her Plunket work experience:

> You...see a mother and think you know how she feels...You sit back and you think, "I've come a long way." And you never think you would have, but you have... I can see that this is what I wanted...I could never have appreciated it, if I hadn't worked where I was working, in Plunket.

Working as a Plunket nurse, Noreen gained a sense of belonging:

> Knowing that you are trying to do a good job and actually seeing that you are doing it. If you thought that you weren't doing a good job you'd lose your strength. I like to think that I might be a good person and so Plunket for me is like finding one's little niche in life.

Although Noreen had not found all aspects of Plunket work easy, she appreciated that through it she had become more flexible and more capable. Other nurses mentioned seeing similar changes within themselves (see also Chapter 4). Kate, discussing what she found rewarding, said:

> We may have given something to others, but probably got a whole lot more back from it. I don't know if I could have coped with all the crises within my family if I hadn't been doing this...It has broadened my views ...humbled me and taken me off my high horse.

None of the rewards listed are extrinsic. They were all intrinsic associated with seeing personal gains made by others, and making personal gains themselves. Philippa said that the main thing for her was that she believed in what she was doing: "Otherwise," she said, "I just wouldn't have stayed. The frustrations would have outweighed the rewards."

THE CONSTRAINTS

What is not so rewarding about being a Plunket nurse?

Is there anything that prevents you from working in the ways that you would like to work?

Unlike many of the other questions in the interviews, but like the question on rewards, these were easy to answer. Again, the nurses did not spend time thinking about what was constraining or what was not rewarding. They already knew. One of them said, "The bureaucratic crap. It just about kills you. That's what's not rewarding." Indeed, many of the factors listed as constraints were connected to bureaucratic structures, norms, goals and policies, but these people also found themselves constrained by factors outside of Government and the Plunket organisation. Their responses are arranged in the following sequence: constraints external to Plunket; constraints within Plunket; selves and colleagues.

Constraints External to Plunket

Constraints external to the Plunket organisation, as perceived by the participants, fell into three main categories: constraints related to Plunket policy, to service users and to other health workers.

Policy Makers

All of the nurses mentioned Government policies as limiting the Plunket organisation and thus the practice of Plunket nurses. These limits were seen in terms of cuts to funding and Government influence on the contract signed by Government and The Royal New Zealand Plunket Society. A lack of understanding on the part of policy makers within Government (see Policy Makers, Chapter 6) was seen by the nurses as the reason why funding was so limited. The problem appeared to be twofold: the people who made the decisions were not in a position to see either the social reality of surviving on a low income or that of Plunket nurse practice. What Wendy said was representative of the other nurses: "I don't think they understand about any basic health systems, just as they don't understand education. I don't think they understand what is happening out in society." This statement relates closely to a major theme, which can best be summed up by the phrases: 'They don't understand'; 'They can't see what we see.'

From the responses, it was difficult to ascertain whether Government or Plunket policy decisions were responsible for what were described as constraints. However, even when Government policies were responsible (for example, limited funding), the results were felt within the Plunket organisation. Therefore the results of policies that nurses found to be unsupportive will be discussed in more detail under 'constraints within the Plunket organisation.' Constraints related to a changing organisation will be addressed further in the following chapter.

Service Users

One source of anguish was a family, which could benefit from the support offered by Plunket, choosing not to take up the option. As Noreen said, "It's there if they want it...If they don't want to let you over the doorstep, they don't have to." And Philippa made the comment: "Sometimes you do your best to explain the service to someone and they still don't use it." As with policy makers, the Plunket nurses in this study found that many of the people using their services did not understand the full extent of what was offered. Either these people were unaware of the changes to Plunket nursing and expected the service to continue as before, or they were members of social groups who had seldom if ever used Plunket services and therefore had little or no awareness of them (Service Users, Chapter 6). Overall, false expectations or ignorance on the part of people who could be using their services were major factors in the level of frustration that these nurses experienced. Many of the nurses spoke of the need to educate parents about Plunket services in order to practice in the way that they saw as appropriate and to meet the Plunket organisation's requirements (objectives which do not necessarily agree with each other).

Fay and Trish worked in different parts of the North Island, but in areas that were demographically similar with the majority of residents living on very low incomes. Trish's description indicated that it was not just a lack of or false expectations about Plunket that kept people away. Sometimes it was the constraints placed on families by the social conditions under which they lived. As she talked, the process of a developing relationship between her and those using her services became apparent. Her response here suggested: that social constraints on families can restrict their use of services; that a community nurse can develop insight into the problems faced by these families as a result of her work experience; and that when the approach of this Plunket nurse is supportive rather than controlling there can be positive outcomes for both nurse and family. Though she began by talking about constraints, Trish ended with the joy of her work:

> I work in an area where a lot of families on low incomes live. Well Plunket to them is such a minute thing in their minds. They've got so many other problems...You might say something to them and you won't see them for two or three months and then all of a sudden something comes up and they'll come back. At the time you think you've lost them, but if you leave them alone for a while they get over it. I'm quite amazed at some of the young mums that I've got. They do listen. I've got ones that are fourteen or fifteen years old, and they really are quite good. A lot of them are lacking in confidence. It takes a long time for some of them to accept you . That's what I like. The challenge of trying to get them to accept your visits. Some of them are that shy it's a challenge just to get your foot in the door...Some...don't think they need Plunket, but then there are others who will come to clinic and onto your committee.

This quote highlights why these nurses placed so much importance on visiting people at home. Before people will visit a clinic they have to be sure that it is safe. That is, they need the opportunity to learn that the nurse concerned can be trusted.

Even in areas where most people are familiar with Plunket services, the changing nature of Plunket means that there can be unfamiliarity with the Plunket approach (Chapter 6). Trish mentioned that in some instances the cuts to services were not helping the already problematic relationship between nurses and volunteers: "They feel that they have been let down...some of the mothers who are doing the work for us, who are raising the money...they are not getting the service they were expecting." Wendy also spoke about constraints in relation to a changing organisation:

> It is really frustrating because we are told that we are to do certain things and they are going to affect the clients quite a bit. So you try to tell your clients without getting them agitated...and you just get that set up and someone turns around and tells you, "No, that's not what you are going to do...we are going to do it another way." You then have to turn around and tell those same people that things have changed again. It's just frustrating...It looks as if we don't quite know what we are meant to be doing and I don't like that.

The reduction in the number of consultations per infant was one of the most recent changes, and nurses were not finding it easy to explain to families why they were not seeing them as often as previously. Philippa expressed delight about working with a woman from Europe who did not have fixed ideas about Plunket. This woman did not expect visits according to a rigid schedule and she was quite happy to contact Philippa when she had a problem. Philippa said, "Her expectations were different. When the public's expectations are different it's easier." Those new immigrants most familiar with a Western-type culture are most likely to adapt more readily to the New Zealand health system, because although they had some familiarity with it they had no prior expectations of Plunket.

In summary, many of the nurses talked of the pain of trying to help families who would not or could not, for one reason or another, be helped. As Trish suggested (above) a family may not use a service regularly because of the weight of other problems. Other reasons for a family's choice not to use the service included a lack of

understanding of what that service entailed. It appeared that because of the changing nature of Plunket nursing there were an increasing number of people whose idea of Plunket did not match the reality. Nurses were finding that they were required to put an increasing amount of energy into keeping people informed.

Health Workers

The third group of people outside of Plunket who did not comprehend the full extent of Plunket nursing were other health workers (Chapter 6). Again, this lack of understanding was constraining. Philippa illustrated this when she quoted a general practitioner as saying: "Don't listen to the Plunket nurses, they don't know what they are talking about." She described negative feedback from other health professionals as "the pits." She also gave the example of a practice nurse undermining her work by advising bottle feeding when she had been working with that particular mother to maintain breast feeding. She concluded:

> I don't mind the client putting a baby on the bottle. That's their personal decision, but I hate it when they've been trying, and you've been trying, and another health professional who they respect, comes in and throws them into a quandary.

Mary spoke with concern about the perceptions of other nurses. She, too found that nurses whose work was most similar to her own, tended to be the easiest with whom to work (see also Chapter 6):

> We don't need other nurses to criticise us. Practice nurses are good, because they're similar, and they're dealing with the same clients. Some practice nurses do home visits. They're even better. They really understand what you're going through. They liaise well. (With) hospital nurses...amongst the nursing hierarchy, esteem of Plunket is the lowest. Nurses don't need enemies. They've got each other. Other nurses can be so unsupporting, specifically to Plunket, but to each other in general. I think that's a characteristic, but an unfortunate one. There's a power thing going on in the hospital amongst nurses...I don't know how you make them see that Plunket does a good job.

The influence of the Plunket tradition emerged again as a constraint, in that, the expectations of other health workers could be shaped by what had been the norm. Robyn noted that health workers newly arrived from other countries have no pre-conceived notions about Plunket, and therefore can be easier to work with:

> There's a (Sri Lankan) paediatrician (who) has just started working here...She came in to see me to find out what the Plunket nurses do...She took away a chart and a health development book, and she's willing to learn, but there's lots of general practitioners that wouldn't have a clue about what we do.

She added that it would be helpful if some general practitioners made a similar effort to find out about the work of Plunket nurses. One of the nurses **had** worked with a

paediatrician to establish a bigger centre, with more resources, available for public use, but their vision was not shared by others:

> We had all sorts of brilliant ideas, but they were all cried down by local people at the top, who didn't have vision but who had too much power. It just became a frustrating dream. When the paediatrician came we'd grieve about it. Sometimes I feel the most willing people to make changes...are the (Plunket) nurses. It's very hard to get change anywhere else.

Lynn had a story with a similar ending: "One of my goals is to establish a paediatric meeting with the paediatric charge nurse, paediatrician, public health nurse, asthma educator, those sort of people. I tried to do this several years ago...[but] there wasn't enough support for it."

The invisibility of the work of Plunket nurses adds to the difficulty of other workers forming accurate perceptions of it, and thus to the difficulty of networking. Mary said, "Nobody sees what you do." Plunket nurses' goals with other health workers often included looking for ways to overcome constraints relating to others' incongruent perceptions of Plunket, but a lack of surplus energy was one reason why more time was not spent in improving work related networks. Lynn, talking about an on-going goal to improve working relationships, said that there were a lot of constraints related to time and accessibility. The lack of time belongs more with constraints within the Plunket organisation, but Lynn's point about accessibility belongs here in the social context of Plunket nursing. Just as it can be difficult for others to contact a Plunket nurse who is on the move, it can be difficult for a Plunket nurse to contact other community workers who are also on the move. And like Plunket nurses, other community workers are pressed for time also.

A further problem was connected with mobility and communication. People often leave their own particular part of the community to obtain many different services including those of health workers. Neighbourhoods are not self-contained units. This complicates the work of anyone practicing in the community. Noreen felt that she should spend more time getting to know general practitioners, but she said, "My families go to so many doctors, I would have trouble coping with all of that."

Some problems associated with an overlap of community health services are connected to deficits in mutual understanding, communication and reciprocity. This can become evident when health workers from a number of different agencies are involved with the same family over the same time period. For instance, Kate said: "A doctor thinks he's the only one working with the client. We think that what we are doing with the client is [everything]...That's an area that needs to be smoothed out." This lack of reciprocity on the part of other health workers was generally perceived as a problem, and was highlighted by Hope:

> I make sure I see it through and get back to them (other health workers)...I feel an obligation to follow through something that they've requested of me. I get a lot of referrals from general practitioners, the Department of Social Welfare, paediatricians, all sorts of people.

When asked if she received the same sort of feedback as she gave, she replied: "No, it is a bit one-way...You know I don't get much feedback at all. If I want feedback I have to ring up and find out myself." Trish had a similar experience: " If you pick up a heart murmur or something you write to the GP of that family, but they don't notify us of what they find." However, some general practitioners worked more cooperatively than others. Of the two general practitioners who practiced in the suburb in which Trish worked, she said that one was not interested in Plunket: "He won't do anything; nine months checks or anything. But the other one, who has just come, I am getting on quite well with." She talked about how she and the newly arrived general practitioner had been able to work together with a few families in which there had been instances of physical abuse. Trish added that Plunket nurses in her locality received notification of all children under five who were admitted to the local hospital. She said, "It's really good because it keeps us informed." To receive this kind of information regularly from another agency seemed to be something of an anomaly, but a very welcome one, in the nurses' experience.

To sum up, a lack of understanding, including a negative image of Plunket nurses, plus an unwillingness to work on a cooperative basis, emerged as the underlying problems that most of these nurses encountered when attempting to work with other health workers. Although improving relationships with general practitioners were appreciated none of the nurses in this study spoke of working in partnership with a doctor.

Constraints Within the Plunket Organisation

At the time the interviews occurred, The Royal New Zealand Plunket Society was undergoing restructuring. Changes, which have continued to occur, could render some of the following obsolete. Formerly, Plunket nurses had very little input into the formation of Plunket policy, which happened at the executive level (Chapter 1). Trish said, "Well we haven't been that happy because we feel that most of the policies have been made for us, but I think that might improve. Now that there's this new structure and director of nursing...there is more Plunket nurse input."

The participants in this study discussed a wide range of constraints that fell within the boundaries of the Plunket organisation. Some of these hindrances came under the umbrella of problems of communication, and others were connected to a lack of

resources arising from limited funding. Therefore the following discussion is organised under two main sub-headings: 'communication' and 'limited budget.'

Communication

Problems in communication, that gave rise to the lack of voice of Plunket nurses, appeared to fall into two main categories, namely: blocked communication and a lack of shared understanding.

blocked communication

From the nurses' reports it seemed that blocked communication channels were one of the reasons why there were misunderstandings within the Plunket organisation. Philippa and Mary both stated that there was no communication; up or down. The following from Fay was typical of the nurses as they talked about trying to get messages **to** policy makers. When the messages did get through they were discounted:

> I can't do much about changing that (the Plunket organisation). That is really a most frustrating area, because they just don't seem to listen to nurses. We put in good submissions. We spent a lot of time and study days and talked and wrote, and it looks great, and "Yes that's terrific," and nothing's taken any notice of. After a while you say, "Bugger it," and just carry on with what you can do.

There was also a problem with messages coming from the Executive. Wendy reported that nurses never really knew what they were meant to be doing because of "the lack of information coming **from** head office."

Sometimes 'noise' in the system blocked communication, especially parallel communication. When I asked Kate if she had conscious goals that she worked towards in relation to other workers, she said that it was difficult to set goals with other Plunket nurses because of constant interruptions. "We do set them," she said:

> ... and we follow through on what we plan, but it's constant interruptions. It's like being home when you've got all these pre-schoolers. Why one goes to work in a place like this I don't know. You're planning what will happen and you've got clients coming in with a whole lot of other things all the time. Sometimes it's chaos.

From the nurses' accounts, there were neither clearly operating communication channels within the Plunket organisation nor a willingness to listen on the part of decision makers. There were also problems in communication at the local level. Given these problems, a lack of understanding about Plunket nursing was not so surprising.

a lack of shared understanding

Both Susan and Philippa thought that policy makers within Plunket did have a good understanding of the reality of Plunket nurse work, but Philippa also thought that they did not act accordingly: "They often expect too much of the Plunket nurse or they under-utilise her skills...I think, whether it's deliberately or blindly, they choose not to use the understanding that they have." But Susan and Philippa were in the minority. The majority thought that decision makers did not understand their work.

Difficulties experienced by the nurses within the Plunket organisation arose because the protagonists were acting from different premises. This was part of the problem between nurses and volunteers (see also, Chapter 6). Wendy, who was familiar with the views of Plunket volunteers because she had spent many years working as one, said, "Well I think there's been a real hiccup in the policy making in Dunedin, because it has been made by people who have no nursing experience and you can't make policy if you don't know." Others also expressed concern that non-nursing people were setting policy for Plunket nurses (Chapter 6). As well as the volunteers, the Medical Director of Plunket was perceived to be extremely influential. One nurse saw the former Director of Nursing as having her hands tied with the Medical Director having the most influence over policy. Comments like, "It's the most ridiculous thing in the world to have a doctor in the most powerful position in a nursing organisation," were made. Norton (1990:33) states:

> Although the Director of Nursing Services and the Director of Medical Services hold equal positions within the structural organisation, discussions with nursing and medical people involved in the voluntary organisation suggest that the Medical Director is regarded as the principal professional person. Media coverage, in particular television reporting, supports this notion. Whenever a comment on Plunket nursing is required it is the Medical Director, rather than the Director of Nursing Services, who makes the public announcement.

There was general agreement that Plunket nurses as the experts on Plunket nursing, should have a major voice in setting policy, and there was a chorus of discontent about their own lack of voice. After all Plunket nurses were in the best position to asses the needs within their areas of work, and, given their professional expertise, to offer advice on how best to address these needs.

Mary said, "I don't think that they [decision makers within Plunket] know what the reality is." (Again the invisibility of the work was part of the issue.) One nurse was more specific:

> Although we are all meant to do it the same way, the needs are different and the Plunket Society doesn't recognise this and that makes me very angry...How I work...is going to be totally different to the way the nurse...who is only next door works, because we are talking about two different areas. We've got different ethnic groups, we've got quite different social strata, and can't be compared.

> That's not recognised by the Society. We're told that we must see that many people, how many times and we must do that many clinics. ...It just cannot be run that way...They talk about the Treaty of Waitangi and cultural sensitivity—that's rubbish...They talk about it but they **don't** know. They **don't** recognise the cultural differences...But I think a lot of the nurses do and I think a lot of them practice it...We've got a couple of health workers which is brilliant...We've got a Maori health worker, but to me that's nothing. They're still telling us that we have to do the same things. Everybody. It's just stupid. Even the Maori health worker has to fit in with their niche. She has a special role and it is done differently and you have to accept that because there are differences...I just wish that the Society would recognise it ...they **don't** at all,

Hope picked up on the concern that the Plunket Society policy incorporated unrealistic views of what it was like to be a parent: "We have to do silly things that don't mean anything to the mother... You are restricted in that you've got to work so much within Plunket policy all the time." Lynn said, "We seem to get really bogged down with the hierarchy making decisions about what we do, but not understanding the implications." Beth expressed concern for people receiving Plunket services. She suggested that a survey would help to improve policy makers' knowledge of peoples' needs (Chapter 6).

Decisions made at the top have powerful implications for the nurses, but there are also problems at practice level—within the relationship between Plunket volunteers and nurses, for instance. Talking about the difficulty of working with a particular Plunket committee a nurse said, "In reality the problem with volunteers was only with one person, but she was a very strong person and was leader of the group...hard to work with. It takes a lot of energy." Of another committee, Mary said, "I didn't practice in the way they wanted me to practice and I will not. It took an adjustment for them [to see] that I didn't see Plunket in the way they saw as important." In this instance the volunteers showed strong resistance—both spoken and non-spoken—to her practice:

> Like...these open clinics...a lot of resistance from the committee. They were amazed that clients came. I was seeing more...or the same number of people (per) day when I had an open clinic in the morning. They didn't like that. I felt really strongly constrained . (Also) if I went into the clinic on a non-clinic day to use the phone I felt I had to justify my presence there. It's as if you were supposed to be there at certain times and not be there at other times, and I don't think it was me being paranoid about it...I don't think they understand what the job is. They don't see what we see.

'They don't see what we see' was a dilemma that seemed to pervade the Plunket Society at all levels. Two nurses talked about the different approaches of Karitane nurses and Plunket nurses. One of these who worked in a family centre said, "The other frustrating thing is that I am constantly working with Karitane nurses not Plunket nurses, even though they are very knowledgeable and very good...It's just that if you are a general nurse you want someone who understands your concerns." I asked her if

this might also be important for a Karitane nurse, and she replied, "Definitely... sometimes they don't see us as practical."

A variation on the theme of others acting from a lack of understanding appeared when I asked nurses about their formal Plunket education (Chapter 4). Here they talked about students being presented with case histories with idealistic outcomes, thus setting trainee Plunket nurses up with unrealistic expectations for their work. Trish saw the focus on ideal practice within the Plunket course she had taken as a constraint: "They don't tell you that a lot of these things you'll never solve because they are on-going...I felt a responsibility to reach a conclusion, but very rarely do you have a conclusion." It would be understandable if some teachers, striving to prepare the most effective nurses, forgot some of the realities of the work. However, a teacher who does not address the full reality of Plunket nurse work—for whatever reason—is akin to a policy maker who makes the same omission. As a consequence, Plunket nurses are given unrealistic work expectations and are set up to experience failure. Several of the nurses in this study commented on how difficult they found the work to be when they first began doing it. Courses that give nurses unrealistic expectations of work outcomes intensify these initial difficulties.

In contrast to others within Plunket, Principal Nurses in the areas in which the study occurred were seen as understanding the realities of both nurses and service users. Beth, for example, commented: "Our Principal Nurse is really informed about what we are doing. She understands the communities we work in. She knows that people who live in different areas have different needs."

Kate picked up the theme of invisibility by talking about a lack of public relations (Chapter 6). This problem of invisibility is internal (within Plunket) as well as external, and is partially responsible for the problems in communication between different people working for Plunket. Policy makers and volunteer workers within Plunket could not see either why Plunket nurses were choosing to work in the ways that they were or the kinds of changes that happen within families as a result of these efforts. But further than that, it seemed that even when the nurses tried to be heard, no-one was listening.

A Limited Budget

When asked about constraints on her work, "Lack of funding" was Trish's immediate response, and Robin said, "Lots of things that we want to do, we can't do, because the money isn't there." The two main constraints arising from a limited budget were a lack of resources, and a lack of time.

a lack of resources

Plunket nurses dream about more resources. One nurse, sharing a desk with Karitane nurses in a family centre, said:

> I have no office (of my own), which I am finding increasingly frustrating...There is nowhere for anyone to use a phone that's private. Karitane nurses might be using the desk when I'm waiting to use it. They haven't got their own place. It is very difficult to work here.

Susan said, "I'd like a community based room...a nice big comfortable room that they [families] can feel comfortable about; and quite a few toys; and a few white-boards on the walls; and nice pictures." Similarly, Kate would have liked to work in a larger centre with more educational facilities and more welcoming space in which people could relax.

It was clear that needs were far greater in some geographic areas than in others, but all of the nurses, even those who were working in areas where people were living on higher incomes, gave examples of how their work could be enhanced by an injection of resources. There may be a conflict of ideas between nurses and volunteers, but the hard work of the volunteers was appreciated by the nurses. All nurses spoke appreciatively of the energy and commitment of the people working on their Plunket committees (Chapter 6). As Wendy said, "We couldn't function without the volunteers." Philippa summed up the problem which affected volunteers as well as nurses:

> Lack of money would be the main thing. Lack of money to provide more culturally appropriate health workers, more Plunket nurses, more family centres. You need community based units that people can relate to.

Although I have subsumed a lack of resources under limited budget any lack of support to Plunket nurses could equally well arise from a lack of comprehension about their work on the part of decision makers. The same is true of a lack of time.

a lack of time

"Time constraints," "Lack of time," "Time is a major thing," was the chorus. Even Wendy, who talked about how she needed to be well organised, felt time as a constraint: "There are certain people who I would like to see and spend a lot more time with...I could give them a lot more help if I could have a day and just work with them. There just isn't enough time." Lack of time also intensified other constraints. Asked about her goals with other health workers, Fay replied, "I haven't had a lot of contact. Not as much as I should have had. It's finding the time." There was agreement that if more people could be employed, work which was not being done could be done. Although the number of consultations required for each infant was reduced, it seemed that the

pressure of time was increasing. Comments were made about the decreasing number of Plunket nurses. Several nurses mentioned that two nurses had left one area and had not been replaced. Those who remained were required to absorb these case loads:

> We've got these high work loads...I ended up with 250 babies (under 1 year) under supervision in the area I worked in—awful. All that pressure of numbers...There was no time to plan.
>
> We have had to reduce staff and we're making do.

Beth had gone through her files recently and had found a letter that she had written in 1983. This letter spoke of a lack of support and the increasing pressure of time:

> I felt what we needed was an extra person so that we could run small groups...The new person would have to do all that extra work. Getting the people there. Organising it. I never got a reply. Now we have to do all these courses and they still haven't come to terms with how much harder it is in (a lower socio-economic urban area).

Another statement of Beth's, which described a need for the employment of more Maori health workers, also related to the themes of a lack of support and a lack of time:

> Maori health is the poorest in the country. We still have not really addressed this issue. I think it is a very sad state of affairs. I think individual nurses try very, very hard ...but I think there are many, many young Maori people who we have not helped. If we want to make (Aotearoa/New Zealand) an equal society we have to put more resources there...We now have a Maori health worker...She is not supported and they want her to do lots of other things as well. We need more people like her.

Several nurses, expressing concern for a Maori worker practicing in isolation within the dominant culture, stressed a need for more Maori health workers working together to provide mutual support. They also indicated that there was a need for health workers from racial groups other than Maori and Pakeha.

Trish connected time to quality of work; to the process a nurse used. Her following statement placed quality before quantity and raised the possibility that the nurses could manage their time differently:

> Over the last couple of years I have decided that it's not really the numbers it's how you help people...Some days I might only see a few people, but with that three or four I've still been working all the time. I can give that family more support. Now I feel more satisfied in myself and I don't get through the numbers the same.

It seemed that the nurses' experiences of time constraints are derived from a number of sources, not just from a lack of money to employ more people, but this latter was of major concern. The quality versus quantity argument presented by Trish is connected to the emphasis placed on numbers by decision makers. It is also connected to the nurses' insistence on the importance of home visiting to the positive outcomes of their work. To

build trust and to improve the quality of relationship takes time. Added to this, the nurses who experienced Plunket courses that presented an idealised view of their work (see Trish above) are set up to feel time as a constraint. Because they have been taught to have unrealisable goals they will never have enough time. They need a miracle.[1]

Selves and Colleagues

I have suggested above, that although a limited budget is an important factor, the nurses feeling pushed for time rests on more than their very real need for additional co-workers. Change could be most constraining for those who have been working longest for Plunket. The suggestion that the established tradition of Plunket had some power over the thinking of nurses was implicit in a statement made by Philippa, who was relatively new to Plunket work: "Within the organisation of Plunket, the other nurses feel such a pressure of numbers. I've never felt that. I only saw people as their needs required." Mary also saw herself as being at an advantage to other nurses, because she too had entered the Plunket nursing service more recently. Even so, both Mary and Philippa did say that when they first started working for Plunket, they felt out of their depth at times. Philippa gave an example:

> ...especially in situations where a client didn't want to do anything about what they had told you. (When) it was sufficient for them to have unburdened themselves to you...so learning how not to carry it...that was a biggie. I'm sure a lot of that comes with maturity.

This is similar to other nurses saying how difficult they had found the job to be at first, but that they had learnt how to cope. Susan said, "I've come a long way," and Fay talked about setting limits:

> I know a lot of nurses spend a lot of their own time...working late, following up visits here, there and everywhere...I don't do that...I did to start with. I'd be running around after everybody. I could see that that wasn't having results. You were just making people more dependent on you.

Thus learning to cope with the pressures of work required learning to allow people to own and solve their own problems; to allow and encourage independence.

When I asked about self-limitations, several nurses mentioned a lack of confidence. One was still overcoming a fear of other health professionals instilled in her when she was a student nurse: "When I trained you had to stand up every time a doctor walked into the room. I've still got a lot of those feelings." This echoed my experience, in

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[1] Further discussion on time as a constraint and on current changes which offer the nurses more flexibility, allowing them to organise their time, appears in Chapter 9.

Christchurch Hospital from 1958-1963 (see also Chapter 1). A younger nurse talked about her increasing confidence as she gained in experience, and yet another wished that she had more imagination. She said, "Some people can go into an area and think, 'This, this and this needs to happen and I could it achieve it this, this, and this way.' Well...I would take longer." The nurses who talked about courses they were taking, or would like to take (Chapter 3) to improve their knowledge and skills, were demonstrating an awareness of their own limitations.

Philippa talked about **intentionally** limiting herself in her work in order to avoid putting her whole life into Plunket work. As well as protecting herself Philippa wished to avoid encouraging people to be dependent on her. Kate said, "I think there will always be self limitations. You can't be everything to all people." Fay discussed the problem of remaining detached in more detail:

> I say I leave my work at the door, but I don't really...I don't bring unnecessary stuff home with me, but there are still things—. They don't keep me awake at night (as) they used to. I used to get phone calls right through the day and night, which I don't any more because I don't give my number out.

It is possible that the nurses' management of time, in response to the demands placed on them by the Plunket Society's contract with Government, depends also on their own adaptability, confidence and skills. Wendy experienced some frustration watching colleagues who were less well organised:

> I like to get my day really structured and I like to be away in the morning. It doesn't really worry me if my day is changed. I can cope with change. I just find that some people don't get themselves organised. Then they think that they are doing more work than other people. If they got themselves organised everything is equal. It is worked out to be equal so that nobody is doing any more than anyone else.

Philippa, like Wendy but for a different reason, described witnessing the work of some other Plunket nurses as unrewarding:

> It's unrewarding when you see your own colleagues practising in a way that doesn't do anyone any good. I guess where nurses are unprepared to change, or are unprepared to present their information in a different kind of a way, or as part of their coping mechanism they just do the job. They don't look for anything more than what they perceive the job to be. In other words, a client might come in who is really desperate about something else but the child will be weighed, looked at, and the books and notes will be written in, but nothing else happens.

The picture presented in the above quote suggests the possibility of a person 'working to rule.' It is not the picture that I have of any of the nurses who participated in this study, many of whom were seeking ways, such as taking courses in counselling (Chapter 3), to become more skilled in helping people with a broad range of problems. Plunket nurses are faced with the dilemma of managing to change their practice to meet

changing demands from their organisation and from people using their services, as well as managing their own reactions to the suffering that they witness, and managing their time in the best way that they can in order to help as effectively as possible. It was Wendy, talking about the personal costs of her work, who said: "I think as I've got older and I've got more experienced I can sum people up better. So I can leave my worries at work. Whereas when I first began Plunket work I was trying to be everything to everybody." This is not unlike the pattern that Trish sees herself as following—striving to achieve the impossible at first and then learning to organise and work in ways that are more in keeping with the reality of the work. Perhaps the nurses in the picture presented by Philippa (immediately above) were using their lack of vision as a coping mechanism. To see further is painful.

PERSONAL COSTS

Are there personal costs in being a Plunket nurse?

When asked about personal costs, everyone talked about stress, anxiety or fatigue, but there were other costs mentioned by only one or two nurses. I will briefly describe these, and then present what was said about stress and its consequences.

The fear of dogs was a concern of one of the nurses. This fear was personal, but had a strong reality base, and though overlooked by the others was no doubt a shared concern. Other nurses re-visited themes already discussed. These included anger arising from the tunnel vision of others and the low status associated with being a Plunket nurse. Susan returned to the question about career, and although she had no regrets, she said that remaining in clinical practice represented a personal cost for her:

> A man or woman in a career, puts out their hand and can see exactly what they're worth. We will never know (what we are worth). We are probably worth more after all, because what is going on in that parent's mind is how those children will turn out. It may be far better than we ever thought.

Implicit in this statement of Susan's is the question of invisibility: How can a Plunket nurse know her (or his) worth when the results of this work are hidden from direct observation? This question could also underpin Philippa's statement, which echoed what others had said about Plunket nurses being seen as the 'Cinderellas' of nursing. Philippa reported that people expressed surprise when she told them that she was a Plunket nurse: "You're a **Plunket** nurse?!" Then she said that she tried to stop herself justifying her choice of occupation, by thinking "Oh well I don't care what you think, I do it because I enjoy it." She added, "That's a personal cost. Everyone likes to have

someone saying 'Oh! That's a great job, good on you.'" Mary commented that she wished other workers valued Plunket nurses, but added that this did not happen.

Anxiety, Stress and Fatigue

All participants valued their work but felt hindered and overworked—some more than others. They were in agreement that anxiety, stress and fatigue were associated with Plunket nursing. Susan said, "It uses a lot of energy," Trish talked of the exhaustion following an open clinic with an attendance of about one hundred children, and Philippa began by talking about how difficult it was not to worry about other people. Fay said, "You know that all the facilities are there...if only they would utilise them and they don't ...The children are the ones who suffer...[and the parents]...they're unhappy too."

The pain of watching people not act on suggestions or referrals which would benefit them was a serious personal cost. Noreen felt she was: "Bashing her head against a brick wall [because] some people, no matter how you go about it, are not ready to make change...We can't do it for them. We can only advise and support them." Plunket nursing is demanding work, bringing nurses into close contact with the joys and tragedies of others. The anguish associated with tragedy is particularly poignant when the person suffering is young, innocent and helpless. Philippa, talking about knowing that some things will never change, said: "At the bottom of the heap is the child who is going to be most affected by that lack of change, that is the constant sad part of the job."

Working overtime caused concern. Noreen remarked that most if not all Plunket nurses, including those who worked part-time, worked in their own time. Trish was one who worked overtime in order "to maintain [her] standards." She added that as a part-time worker, she found it difficult to take time-in-lieu for the study days she attended in her own time: "If you do that you are so rushed off your feet it's not worth the hassle to your health." Kate, who worked full-time, had a similar problem:

> The fatigue—it is really tiring. Especially when you have a day of lots of problems and a group that doesn't go well . Then I'm not feeling good for the rest of the day ... You have meetings at night that might go on for three hours and you think, "Well damn it. I've been at the centre all day. I've torn home, swallowed my tea down whole after preparing it. I've hardly seen the kids. I don't know whether they've done their homework and you are back here and you have not had a minute to yourself all day. You are supposed to take time-in-lieu, but you can't always take it. If you do take it you are putting stress on the other staff...One Saturday I had a family conference. I was there from one to four... and there was my Saturday gone. And then I had a meeting on the Monday night. I was meant to take a whole day off to make it up. Yes it is emotionally draining.

Beth, who worked part-time, talked about the fatigue she observed in those who were in full-time employment. She said that in one area these nurses lasted for about two years. "After that," she said, "There is nothing left to give." As the nurses talked about the extra hours they put in, they thought of the savings made at their expense. For example, Noreen said, "None of that comes into the costing of Plunket. Therefore, Plunket gain an awful lot from their staff, and I don't really think that they give credit for that."

Mary said, "There is no energy left at the end of the day to do anything." But at the end of the day, Plunket nurses do face further Plunket responsibilities. Kate (quoted above) gave details of these. Robyn, referring to the statistical work and the committee meetings after a full day of home visiting or clinic work, said, "Some nurses in the rural areas have four sub-branches to deal with; meet their needs, attend their meetings. And calculate all the statistics at the end of the month. This is why the country girls get lost... They can't do it all." Committee meetings with Plunket volunteers involve looking after the relationship between nurse and volunteer (the person who holds the purse strings). Looking after relationships is hard work and Plunket nurses have been doing this all day. Moreover, for most, this kind of work continues when they get home. Hope said, "Peoples' problems do tire you out especially with the fact that you don't off-load very much. It is emotionally draining. You're all the time giving out, giving out, giving out. "

Consequences

At the end of the day, anxiety and fatigue come home. Lynn reported going home feeling totally exhausted and not wanting to be with her family; just wanting space. Hope's experience paralleled Lynn's: "When I get home I don't want to see the people who I really care about, and my husband, who doesn't see people, wants to talk. If there's anyone under five, I certainly don't want to see them...It costs me heaps. It creates conflict." Trish, concerned about finding time at the end of the day to relax, noted that the difficulty of balancing paid work and family commitments:

> We always have a chat at night about what we've done for the day. That's really helpful for us...To try and keep communications going (is) hard, especially with the teenage pressure and knowing they are always out. I try to keep the family together; to be a family.

Kate did some soul searching, saying, "Each weekend I think to myself, 'Should I really give up?' There are certainly personal costs if you've got children at home. If you work full time there's not a lot left when you get home ...It is hard to do both, because it's two careers." Wendy, whose children were adult, could reflect:

> (There are) probably not as many personal costs to me now as there were when I still had children at home. There were quite a number of personal costs then. I think as I've got older and I've got more experienced I can sum people up better. So I can leave my worries at work. Whereas when I first began Plunket work I was trying to be everything to everybody. I would be so worried about what was happening and I was thinking "My god, I can't sleep tonight" and my children were suffering. I've got over that now. I realise I do the best I can in the hours that I am given.

The combination of two careers—family and paid work—left the nurses little time for themselves. Hope, like Kate, would have liked to be involved in other activities in the evenings:

> It costs me. I'm tired. I'd like more time for myself...I'd like to do a night course, and although some nurses can manage that, I don't seem to be able to. I don't know if it's just my kids at the age they're at but I just cannot manage to go out. I haven't got a zilch of energy left to do anything for me. I'd like to do swimming and I think if I get up early enough—but I can't manage it. I'm in bed by half past nine and until I've had that sleep I'm a goner.

Both were interested in taking a counselling course, but both felt already over-committed. Kate said, "I've still got these two quite young children...Their needs are no less than other children of that age, and I'm just not there for them. That does limit my goals."

With so many constraints how did these people continue to function? To be not highly regarded; to be seen as the 'Cinderella' of one's profession can erode one's sense of dignity and feeling of worth. Where did these nurses find support?

SUPPORT

What things about your job are a source of energy or strength, giving you a sense of your dignity as a Plunket nurse; a sense of your worth?

This question was more difficult to answer. It seemed that support was not readily available. "I sometimes wonder," Susan said, "...I've spent all my energy by about two o' clock in the afternoon and I'm dragging myself around on my kneecaps."

Energy and strength and a sense of self-worth can come from recognition of a job well done. Such recognition can come from others or from oneself. In this section, I will begin with self-affirmation, which is followed by support associated with those using Plunket services and then support from other health workers, including colleagues.

Self-Affirmation

Wendy's view, of the perception of Plunket by others, presented something of a contrast to that of most of the others. Asked what things were a source of strength for her, Wendy said:

> The Plunket image is an image that people respect. I personally wouldn't be looking for a lot of strength myself because I consider that I am a team member and I am not working as myself. I am working as a Plunket nurse and ... I am just another cog in that wheel. So the things that would make me feel good about Plunket is when I am still aware that the work that Plunket nurses are doing is still seen as worthwhile and when it is recognised by other health professionals, like doctors and maybe even parliamentarians, as a service which New Zealand could not cope without.

Of all the nurses, it seemed that the images that Wendy and Susan had of Plunket were the most positive. I think this offered them some protection from the more negative views of people outside of Plunket.

Throughout the interviews many indicated that they thought that Plunket nursing was devalued, even by other nurses. This negative image had the potential to erode self esteem. When Kate heard the word 'dignity,' she said, "That's an important word. That's something you've got to hold on to." Not easy in the light of the following comment from Philippa:

> I don't think there is any dignity to being a Plunket nurse. The name itself conjures up so many negative images in so many peoples' minds that a lot of the time you are trying to combat that. It happened more than once that I would knock on the door and someone would say "Are **you** the Plunket nurse?!"
> I would say, "What were you expecting?"
> "Oh, someone who was out of date, or old fashioned ,or really strict."
> And that was from a client, quite apart from what other health professionals think of Plunket nurses.

The nurses seemed to find it particularly difficult to answer when asked directly about their self worth. It is possible that the negative feedback they received, merely because they were Plunket nurses (and women), helped to undermine their view of their own worth. I wondered, too, if their hesitation was related to a perception of social disapproval for people who promote themselves. Moreover, self-promotion does not feature in a process that is designed to help the other person improve in confidence and self-esteem. That is, these people were spending their working lives promoting other people. For whatever reason, this question was among those that were more difficult to answer. However, there was some response about feelings of worth.

Beth felt good about her work, and Wendy too:

> I come home most nights feeling good and thinking "I've done what I set out to do today. I have not done anything that I should not have done. If I have, it was never done intentionally, and I am happy to go to work tomorrow.

Fay was one of the nurses who worked in an area in which financial poverty was highly visible and she talked about self-affirmation: "I enjoy being there. I don't want to be anywhere else... I've made it what it is." Many of the nurses in this study found it difficult to give themselves credit for a job well done, but all felt good about the positive changes that they observed in the families with whom they were working.

Service Users

All of the nurses were energised by seeing positive outcomes for families using their services. As Philippa talked about this, she said, "You've got to get the rewards from the client, whether they are spoken or just observed, because you are not going to get them from anyone else." More specifically, Lynn said that a sense of worth came from:

> Often very subtle things like body language. A lot of people still find it difficult to say thank-you, but I find a lot of parents (do). Sometimes I may not have any answers for them, or we seem to have exhausted all the possibilities...and then a mother will turn around and say, "That's OK it's just good to talk to you." Those sorts of things do give you a buzz.

Trish described a sense of dignity coming from sharing her knowledge and consequently seeing an infant who was not thriving begin to flourish. "From this," she said, "You can see that what you are doing is really worthwhile." Kate said:

> Where do I get my energy? From the people...we have had young mothers who are now going on to Kohanga Reo and training to be leaders. We did play a part in that. So that's a real boost. When you see things are different with the second baby, or the second year of their parenting, where they have matured and grown. I know that we have not been all of it, but we have been part of it.

As discussed earlier, when the nurses talked about rewards, they mentioned the affirmation they received when families attended their open clinics, and when a person become more confident in the role of parent. The positive results of their work were an important part of their support; an important source of energy. They received some support also from colleagues and other health workers.

Colleagues and other Health Workers

Although the support network within Plunket varied in strength from area to area, all the nurses found support within Plunket. Philippa said that even though other people might look on Plunket as a "dead loss, she knew that there were:

> ...really excellent people doing some really good things...I always felt there were people who would support me and people who I could talk to if and when the job was difficult...Other Plunket nurses, particularly at the family centre, and the senior nurse is fantastic. But just my colleagues really.

In one area, the Plunket nurses were working as a team. Those I interviewed who belonged to this team were unanimous about the value of the support they received from each other:

> Every one of the nurses who are in the area ...are doing the same sort of work...I couldn't do the work that I'm doing without being able to share it with others who really understand what's going on...only those nurses know how important it is.
> ...the Principal Nurse is very good too. She's marvellous, and that helps, and our senior nurse. She keeps us all together...It makes the job a heck of a lot easier in many ways, because you have that support and you share.

Hope was among those who talked about the importance of affirmation from principal and senior nurses:

> Our Senior Nurse is really good at seeing that the nurses need to get feedback; need to have time together when they can just talk about things and to share . That's a positive thing but (it) comes from, one individual seeing the need ...It's not really promoted at the top...I can see the benefits...she's really trying to care about people who work here... I get most of my support from her...you've got to have someone you can talk to.

About her Principal Nurse, Hope said, "Approval from my boss recognising what I am doing and that I am doing it well...that is important."

For Hope, affirmation also came in the form of the constant referrals that she got from paediatricians and other health workers: "It's indirect but they wouldn't be doing it if they didn't think I was helpful." Beth, Lynn, Mary and Susan all talked about receiving positive feedback about their work from health workers outside of Plunket. Lynn listed some of these sources of support:

> Occasionally support will come from other staff, a practice nurse, sometimes from general practitioners...certainly from other agencies like Barnados. We do work with those people, and they give positive feedback to us about our work.

Although the nurses had to think hard about where they found support, they did in the end discuss several sources. Some appeared more able than others to find support within themselves. Affirmation also came from seeing positive outcomes to their work and from colleagues and other health workers. In other parts of the interviews participants talked with warmth and appreciation of support from their Plunket committees. This was particularly so when the nurses had been working in an area sufficiently long to have recruited most of the members of their committee (Chapter 6). They were also appreciative of what they were learning from their experiences as Plunket nurses; of the people they were becoming as a result of this work.

SUMMARY AND DISCUSSION

Throughout all of the interviews, there was a clear identification with the people using Plunket nursing services. This was expressed in an appreciation of social diversity and an awareness of the corresponding range of social needs. Support and energy came from responding to these varying needs and seeing the positive results of their efforts, as well as from acknowledgment and appreciation from the people who benefited. Furthermore, a strong commitment to increasing independence for service users was a major motivating factor, and thus these nurses complied with Albee's (1980:100-101) description of professional health worker as advocate. Although they were not experiencing disapproval because of this, they did not have a lot of support. Most of their support came from the people who did understand their work. These were the people who were closest to them (principal and senior Plunket nurses, health workers with similar work or who worked closely with Plunket nurses, and families who used their services).

Constraints far outnumbered rewards, with a large number of factors acting to hinder them in realising their goal of healthier and more independent families. A lack of shared understanding emerged as the major hindrance. This lack of understanding applied to some people using their services, to policy makers in general and to some other health workers. That the level of need varies from community to community appeared as a major part of the misunderstanding between nurses and policy makers. Contract requirements did not appear to take these variations into account but were applied blanket fashion across the country.

There were a number of underlying factors associated with the problem of people not understanding what it is that Plunket nurses do. Firstly, the nurses' work is confidential and its character and results are often subtle and long-term. Therefore it tends to be invisible. Added to this, it seemed that the value and nature of Plunket nursing was not widely advertised and consequently not widely known. Thirdly, it appeared that Plunket was not structured in a way that permitted the voices of nurses to be heard. When Plunket nurses did speak out their message was discounted. Relationship between the service delivery and the volunteer side of Plunket appeared as problematic (see also, Chapter 6). This latter supports Norton (1990:121) who argued:

> ...there is evidence that the service is vulnerable to interpersonal relationships between the people involved in this organisational structure. There are issues of power inherent in the organisational structure of the Plunket Society which have consequences for the interpersonal relationships between the groups involved.

Although I have separated constraints into different categories, often problems crossed the artificial boundaries that I imposed. For example, a nurse talking about the distress of observing child neglect said:

> I find some days quite frustrating. There's a lot of families who have a lot of problems. When I see child neglect I find that very hard. When you struggle with families and you are not making a lot of headway, you wish you had more skills—I think we need more resources. I don't find that Social Welfare is all that great help to us. I feel reluctant to bring Social Welfare in because they are (often) no more skilled.

The problem for the nurse is the anguish of seeing child neglect and being unable to help, but the origins of the problem are many and varied. Both lack of skill and lack of resources were alluded to in this quote, and both pertain to other agencies as well as Plunket.

Lack of resources within Plunket emerged as a major problem for the nurses. Resources were found to be insufficient as the Plunket nursing focus broadened and became less rigid. A clinic which could cope with several family members was inadequate and unsuitable to use for a venue for a playgroup, a parenting class or a support group. Limited funding also contributed to this seemingly worsening problem of inadequate resources.

Pressure of time was a further problem with complex origins. A lack of time arose from: a limited budget leading to decreasing numbers of Plunket nurses and insufficient support staff; a lack of understanding about the nature of Plunket nursing; and the nurses' own level of skill in managing time. The invisibility of a changing Plunket nursing practice and the lack of awareness about it appeared again as a contributing factor. The more time nurses put into educating people about their work, the less time they had for delivering a service. These difficulties would not be resolved if just one of the causes became the focus of attention at the expense of the others. Unfortunately, given the dominant underlying problem of a lack of shared understanding, it seemed that this was quite likely to happen.

The nurses participating in this study were unanimous that there were high personal costs associated with being a Plunket nurse. They identified these costs in terms of stress, anxiety and fatigue resulting in a loss of energy for life outside of Plunket. Nurses who had family responsibilities (especially young children) spoke of the difficulty of balancing two careers and were faced with the very real on-going question of whether or not to continue with their Plunket work.

They agreed also that successful work outcomes and increasing personal effectiveness brought them their rewards. These rewards were intrinsic—feelings of enjoyment and satisfaction, and it was these rewards that kept them in the job: "The

rewards to me far outweigh the lack of them. I know I have put more on the list of the negatives, but as a whole the positives are more important to me" (Philippa).

CHAPTER 9

A CHANGING PRACTICE

At the time that this study began, social change appeared to be occurring on all fronts, and affecting the lives of most New Zealanders. Firstly, from newspaper reports it seemed that many people were facing what might be called 'reversal' in their personal lives: people who thought their jobs were secure, were now 'redundant;' people who planned on their children going to university, now wondered how they could meet this cost; people who thought medical treatment was available to them, now questioned whether they could afford it.[1] Secondly, restructuring of Government Departments and State Owned Enterprises had become a recurring phenomenon. Hospital Boards and District Offices of the Department of Health had recently been amalgamated, and voluntary organisations could not escape this process of change.[2] Finally, from my own observation Plunket nurse practice was changing. This latter was a major reason for the choice of topic for this study ('Introduction' and Chapter 1). Therefore the main focus of this chapter is on Plunket nurse practice, with some discussion of external pressures such as those from the service user group and from policy makers.

As only those aspects of change which surfaced in the interviews will be discussed, the full range of social changes occurring in New Zealand at that time will not be addressed. I will begin with the nurses views on changes that impinge on their work within the social context of Plunket. This will be followed by changes within Plunket, including changes attributed to their own influence. I will end the chapter with the nurses ideas on changes that would help them to improve the service that they offer.

THE WIDER SOCIAL CONTEXT

The broader social context of participants in this study is represented by the social structures of Aotearoa/New Zealand and their global networks, including: the families and communities with whom the nurses worked, the New Zealand health system, governing structures and policies, and the international phenomenon of Western

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[1] During the time that interviewing occurred, at least four formal investigations of social hardhship were in progress (Craig, Briar, Brosnahan and O'Brien 1992; Boyle 1992; Jackman 1992; List, Hubbard and Dolan 1992).

[2] Currently in 1993, all health and medical services face further radical transformation as they adjust to a different structure and system of funding.

medicine and nursing. Although I did not ask the nurses about them, changes in professional thought and technology did surface in the interviews, particularly when participants commented on changes within the New Zealand health system. However, most comment about the wider social context occurred in response to questions on social hardship. In this section, the nurses' ideas about social hardship will be considered following the presentation of their comments about changing technology and theory, and their stated concerns about changes within the New Zealand health system. I will end with comments on relationships with other health workers.

Changes in Technology and Theory

Wendy noted that technology and accepted knowledge had changed with resulting changes in Plunket nurse practice. However, more reference was made to changing theory than to changing technology. Throughout the interviews, ideas related to the World Health Organisation declarations on primary health care (W.H.O. 1978) and health promotion (W.H.O. 1986) were expressed (previous chapters). Here, Philippa talked about the importance of 'individual accountability,' a concept which is fundamental to current ideas about health promotion:

> The whole concept of individuals being accountable for their own health —I just think New Zealanders have been total blobs in that whole area. So even though these changes have been huge, if they at least achieve that amongst a larger percentage of the population that will be a good thing.

She continued to say that if people took responsibility for their own health, they would be less dependent on health professionals. She could see this kind of initiative overflowing into 'client' contracts and 'client' held notes for Plunket. This move towards self-determination was for her one of the major positive aspects of the changes. It is also highly relevant to the partnership that all nurses saw as the ideal relationship between themselves and those using their services. All of the nurses mentioned accessibility, acceptability and affordability as important characteristics of a health service, and all talked about empowerment. Thus the principles of health promotion and primary health care were a dominant sub-text of the responses. Since most of these people had received their basic preparation in hospital schools of nursing, this meant a movement from a focus on sickness to a focus on health.

The New Zealand Health System

As with changes in theory and technology, proposed structural changes within the New Zealand health system were not highlighted in the interview questions. However, from time to time the nurses did comment on these changes. In fact, several began the interview with concerns about proposed changes to this system (Chapter 5). Questions about change elicited concern about the future of Plunket within a divided system. Equity and fragmentation were two of the issues raised. Noreen said: "Each of those four regions are going to have to apply separately for funding. It will depend on how each...see Plunket as to what Plunket gets." Trish, expressing concern that the quality of care in one region might be better than the quality of care in another, said, "If we kept a nationwide service we would perhaps be able to keep a higher standard throughout." Lynn had concerns about the lack of preparation and the speed of change:

> Nothing adds up that will benefit anyone. While I believe we've had it too easy for too long...basically there's been no preparation for the changes. I generally feel very despondent, frustrated and angry with the rapid changes that have happened.

Kate connected the profit motive to Plunket's survival: "We're hoping that it's [Plunket] not going to be wiped because it's not profit making...Surely health isn't there to make a profit." In most cases concern centred on the loss to those receiving the service and to the nation, rather than to themselves. Fay's response was both typical of the others and captured some of the major themes—prevention and the value of Plunket, family practice, problems associated with invisibility—presented in earlier chapters:

> I see it as the most important field of health. It's health and education. It has to start right at the time that the family is formed and it has to persist in being there...There's nothing to measure how well Plunket has done. I think that that can only be told when there isn't one and I don't want that to happen. It really scares me because I know how much work I do...I reckon we have kept a lot of people out of hospital. We've kept them away from the doctor because we've taught or we've encouraged. We've shown mothers ways of dealing with things and they're starting to become better parents...As long as the service keeps going; as long as I can keep doing my job or somebody else can keep doing my job—I see family help as a very essential part of the health system but it is not given enough recognition.

All participants placed a high value on the contribution of Plunket and none could imagine New Zealand without this kind of health service (Chapter 6).

The Question of Increasing Social Adversity

It has been suggested that changing Government policies are causing increasing hardship for families. Do you see any evidence of this?

- *If so do you see these changes affecting the Plunket service?*
- *If yes, in what ways are they affecting the Plunket service?*

Although there was agreement that there was more suffering because of decreasing income, some nurses were seeing more economic hardship than others, and some were more positive than others about policy changes originating at Government level. Susan, the most positive about current social change, said:

> Things are a bit harder these days in many ways, and in many ways not. So I think I haven't seen any more hardship...We are all at different levels at different times. The Government has to cover all of this. They can't pour money into everything, and they say over and over again, "Nobody is going to miss out." ...But there's got to be change and they (Government) have to be allowed to try the changes. They've got to follow it through to the end. I'm quite positive that the system will work and will work efficiently .

Susan ensured that people were receiving additional help as they required it, but hoped that they would learn to help themselves.[3] She added that continued reliance on a foodbank was contingent now on the acceptance of increased support:

> For the last ten years it has been a handout situation, which isn't doing anybody any good. Now, I'm finding something constructive. Instead of a handout, people say, "Right, I'll give you a handout, but tied to that I will give you some budgeting, and tied to that I will see if you are right about your family situation."

Wendy, not as positive as Susan, said that she saw less hardship than she was expecting. People still took their children to the doctor when she advised them to do so. However, she added that a couple of mothers were possibly not eating properly because of a lack of money.

The other nurses were certain that they were seeing more hardship than they had previously. Lynn described what she saw in the area in which she worked:

> All these extra charges—the health charges; the benefit cuts. Those families who have bought a home and are paying a mortgage are having a real hard time. Their actual available income has just plummeted...They're in group three in the health system but their mortgages are such that they are living on a very limited amount. They can't afford health insurance. They're also at the stage in their lives, with young pre-school children, where they will need the health services more for several years down the track. It's just a vicious circle. People can work hard, but they are not rewarded. They have no hope of getting off the treadmill. They have no hope of achieving (their) goals.

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[3] Susan was talking about people who had been on low incomes for a considerable length of time—some for a lifetime.

Fay differentiated between the effects on those who had been on middle incomes and those who had been on very low incomes for some time. What she said about the middle income range echoes with what Lynn said (above):

> In my area where it has always been very depressed, it's just a bit worse, but the problems have always been there....The majority of the people who are living in state owned houses are still in state owned houses. They remain at the bottom of the heap. They're still getting their benefit, which is somewhat reduced, but then they do get free health care now because they've got their Kiwi card—if they've gone and got it.
> ...There are areas also where the people own their own homes and they're the ones where I am noticing the biggest change...A lot of those people have lost jobs—people who have been doing quite well. They're not rich..., but they have their own homes. They've started their family and now they're losing their homes. I'm not seeing too much of it, but it's happening.

Fay continued to illustrate how this loss of income and security was more radical and thus more visible in some areas as compared with others:

> Where I'm seeing it most is with people who were not really affluent but who were trying to do something with themselves. They did have some hope...(Now) the children are feeling the impact of their parent's anxiety...It's really, really hard where the husband's not working and he's very depressed...I just think of one example where the wife had her third child...her husband was working, they had just moved in to their home and things were going along really well. They worked hard and they saved. They were very careful and started to get their furniture and their place looking nice...She had a lot of difficulty with her first baby—like most, but did well. (When her) second child came along I didn't have to do anything very much. It was more of a social call than anything. She always popped down to the clinic to get the kids checked up and she'd ask one or two things but there wasn't any need for me. It didn't take a lot of time...Then when the baby was nine months old she said her husband had lost his job for the third time,...but this time he hadn't got another job. The baby was meant to come back for a year check but hasn't been. Her husband answers the phone. I say "Bring him down if you can." But I've never seen them and I could sense the tension there...That's one example but it's one example of many families. It's become a pattern.

I have quoted Fay at length because what she said was typical of much of what was said throughout these interviews. First she described a woman becoming a confident mother from the time of the birth of her first baby to the time of the birth of her second baby. This confidence was one of the nurses' goals, and therefore a source of reward for them (Chapter 8). Then she traced a journey into despair. Noreen, who worked in an area recognised as being 'upwardly mobile,' observed the same despair:

> They just come into the bottom of group three...Some of them have got two or three mortgages on their homes. A lot of these houses...have still got a lot of money to spend on them even though they look okay from the outside. Every week I get told of somebody else who has been made redundant...We've got men who have been, what I call, 'taken down the ladder and put sideways.' They're getting paid less and (have) to work longer hours, so the family time is reduced as well. There's quite a lot of that going on...Some have been paid redundancy and some haven't...Some have got jobs that include a car, low

> interest on their mortgages, mastercard, and they've got three months to hand it all back and re-finance their house...Just the actual costs of living here are high. The rates to the city council are tremendous, nearly $2000.....The families have been affected. Their health has been affected. The mothers aren't going to the doctor...or (they leave it too long), so that it takes them longer to get better...If (they) are going to have to pay twenty dollars to take a baby to the doctor well then they are going to think twice before they go.

Nurses, who worked in areas where most residents were on very low incomes, described the effects of more severe deprivation experienced by people who had never had the aspirations or the 'wealth' of those discussed above by Noreen and Fay. The changes in the lives of these people were not as obvious, but their customary situation had become worse. Trish talked about the increasing number who were consulting her in order to save themselves doctor and prescription charges, Beth noted that these families were suffering more now, and Philippa said:

> Families have insufficient income to meet their basic needs—having phones cut off, and almost invariably it would be families with ill children who could ill afford not to have a phone in the house. Not having enough money to get good quality food and clothing...A lot of families are not getting prescriptions filled, or getting one item for the child, but not for themselves.

Noreen, summing up the effects of the 'stand down' period between losing paid employment and receiving the unemployment benefit, said, " It has affected housing. It has affected health. It has affected education. It has affected everything." As well as material deprivation there was also a negative emotional response. Beth drew attention to this: "...there's a different atmosphere. There's a feeling of hopelessness in parents and I'm quite sure that feeling is felt by children." Lynn, talking about the Employment Contracts Act, said: "There's a lot of people who are incredibly angry about it...I am quite sure that Government would have no idea of the effect...Men and women...expressing their anger...The child suffers." The nurses talked about observing continuing hopelessness and loss of hope, and the resulting feelings of insecurity, fear and anger. They saw people facing extra demands, which ranged from the tangible, such as hunger, to the more intangible—despair. It was clear throughout the interviews that all of these Plunket nurses were intent on helping families to better their own health. This entailed practical measures such as referral to a foodbank and offering practical advice. Beth said, "I think, 'What would give them the most use if they have to buy something?', because I know it is extra expenditure for them". It also entailed more intangible measures such as offering emotional support.

Changing needs produced new demands on the nurses pushing them to extend their skills and the flexibility of their approach to their work. Hope noted that her work involved something like social work practice:

> Increasing hardship is very noticeable...It's changed my job very much...If a mother comes in and says, "Well my baby's got such and such a problem. She's not feeding too well." Then she says that she's not feeding too well because she hasn't got anything to feed her with. I can't say "Well sorry that's not my problem."

As the nurses talked, it became apparent that the range of their work was increasing and their approach was becoming less rigid. There were forces within the broader social context impinging on their work with sufficient impact to cause them to modify their practice. The changing needs within the families with whom they were working, together with their changing theoretical perspective (see above), were intrinsic to the broadening scope of their practice and their more flexible approach.

The Changing Relationship with other Health Workers

As mentioned in Chapters 6 and 8, relationships with other health workers, including general practitioners, were found to be improving. There was agreement that the image of Plunket was improving and that there was increasing integration with other health services. Kate, commenting on an improved image of Plunket nurses, said: "It depends on the nurses themselves. In this particular area [Plunket] nurses are fairly outspoken and contribute quite well to anything." Trish compared the former isolation of Plunket nurses with the current situation:

> We were pretty limited. We usually stuck to ourselves. Now having a meeting once a month, in the area I'm working in, with all the different organisations, gives me an idea of who they are and what they are doing. I think we achieve more by mixing. I think we are learning to mix more.

Robyn, too, talked about change in terms of more contact with other health workers:

> I think there's been a big change with the liaison with the Area Health Board that doesn't go on in other places. I go to the obstetric unit twice a week...I meet with the obstetricians and the paediatricians and the ward staff (obstetric unit) every Monday for half an hour, and every Thursday with the paediatricians and the paediatric ward and the social workers and the Maori health workers and the public health nurse. We have community liaison meetings in most areas one lunch time a month. That involves everyone including the school teachers and the dental nurses. Sometimes we have a speaker and sometimes everyone just goes around in a circle and says what's new happening in their system.

In the above, Robyn has suggested that increasing contact with other health workers is a local phenomenon. It is possible that one factor in this change could be the Department of Health's discouragement in the early 1980s of public health nurses assuming work parallel to that of Plunket nurses. Trish said, "We have changed. We had to...It came from the Department of Health's decision that public health nurses weren't going to work in the area of 0-5 year olds." Public health nurse practice had

tended to be broader and more flexible than Plunket nurse practice, and until quite recently public health nurses had continued to visit at home until a child went to school. As reported earlier (Chapters 6 and 8), Maori families had tended to use the public health nursing service. Trish talked about her experience:

> When I first came here ten years ago, the public health nurses said that they weren't going to do any 0-5s so we were landed with all the Maori families. It took us about five years before we could see any benefit because they really liked the public health nurses....Also they thought that Plunket was middle-class. I suppose the public health nurses did us a favour , but at the time we didn't think so...Now I think more people are coming in to Plunket. More of the Maori people...It was a challenge to us to try and get these people to accept us. Now I've got two Maori ladies on my committee.

From what some of the nurses said it seemed that the public health nurses' withdrawal had forced them to change their mode of practice. The expectations of people who had been using public health nursing services were different from those who had traditionally used Plunket. But the change had not been easy. Robyn, comparing the changes that had occurred in the area where she worked with areas in which public health nurses were still involved with screening and support of families with very young children, said:

> I think we're sitting pretty over here. We did it years ago and we persevered to get them to come our way and now many of them never think of anything different. A big percentage of them come in. If they don't we'll follow up or arrange to have a clinic in somebody's house and they all come along and they're happy about that and we don't mind.
> ...We have made a lot of changes. It (Plunket) was always classed as a middle to upper-class organisation, but it's not any more.

It seemed that the withdrawal of public health nurses had hastened the change towards more flexibility and a more comprehensive approach in Plunket nurse practice. Working more closely with other health personnel appeared to be positively correlated with this withdrawal of public health nurses. However, all of the nurses interviewed (including those from areas where public health nurses continued to concern themselves with infant welfare) talked about a changing practice and more and better contact with other health workers. It is difficult to see how a changing mode of practice would not effect a response from co-workers. A comprehensive mode of practice in closer collaboration with other health workers plus sound knowledge of what support is available must lead to better comprehension of the nature of Plunket nursing.

Finally, both the withdrawal of public health nursing services from infant care and the cuts to subsidies to general practitioner services have brought more work to Plunket nurses. As Trish explained: "We used to have doctors doing the three year old check [and] they cut that out...Now we are also doing the nine month check that the doctors

used to do." The nurses' workloads increased as that of general practitioners decreased. Added to this, Plunket nurses were becoming fewer.

The Contract and the Changes within Plunket

Do you see Government policy affecting Plunket Society policy directly?

- *If yes, in what ways?*

What kind of changes have you observed in Plunket Society policy since you have been working as a Plunket nurse?

- *What do you see as the sources of these changes?*
- *Are there any trends that you see as positive for yourself as a Plunket nurse and for the women and children with whom you work?*
- *Are there any trends that you see as unhelpful for users of Plunket services; for Plunket nurses?*

In the above section, I have argued that Plunket nurse practice is changing partly because of changes within the wider social context. I have also intimated that nurses played a part in these changes. It seemed that a number of factors were influencing the changes that the nurses were experiencing, and it was difficult to distinguish the exact origins of a particular innovation. I was also unable to elicit a clear picture from the nurses of how the contract between Government and The Royal New Zealand Plunket Society arose, but all were in agreement that Plunket nurses had no part of it. The contradictions and hesitation in their discussion of this document supported their assertions that communication channels within Plunket were not working (Chapter 8).

Although unsure of the process that was followed and of the identity of the main protagonists in setting up this contract, they were pretty much in agreement about what was positive and what was negative in the changes they were experiencing. Kate made a clear distinction between Government and Plunket when she said:

> Plunket change isn't as rapid as the wider change coming from Government policy, because we have been changing over the last few years. Fewer individual consultations and more group clinics have really taken on and people are really enjoying them. We've been talking about empowering people for a long time.

Here she sounded positive about changes that she attributed to Plunket, but when she talked about changes that she attributed to Government she again focused on the reduction in individual consultations and said, "It just makes me shudder thinking about it. I think they [Government] are not interested in what's happening within the service. They have no idea of the mothers and their needs and how we can give a service" (see

Chapter 8). The nurses reactions to the changes they were experiencing were characterised by confusion and ambivalence, but all were adamant that funding cuts were coming from Government and that these were having a major effect on Plunket services.

Restructuring and the Erosion of Plunket Nursing

Changes that were occurring within the Plunket executive and central administration were welcomed. Wendy said that policy should be made by nurses and therefore she saw the restructuring that was occurring in Dunedin as positive; Mary was pleased when she saw a diagram of the new management structure at head office; and Hope said, "I think this has to be looked at as a positive change. This big change up top. I look at it as a last ditch effort...It's sort of like go for gold."

Hopes were high for restructuring at the top, but feelings about policy changes at the local level were not so positive. Summing up her reactions to cuts to services and overall nurse hours, Wendy repeated what others said: "Where there were say five nurses covering an area there are now three. The job is not going to be as well done." Nurses occasionally voiced their own personal insecurity, but, like Wendy, they mainly spoke about their fear that the quality of their work was going to deteriorate.

There was evidence of 'the cookie cutter effect,' with part of the nurses' work going to other workers. Noreen was not impressed by a proposal to employ more health workers and fewer Plunket nurses: "I see this as detrimental. Health workers can assist, but a Plunket nurse has a far wider knowledge base and far more expertise." Fay, also, was concerned about this proposal:

> I think in our area this is probably the most difficult thing...It doesn't necessarily have to be a Plunket nurse, but she does have to have plenty of experience so she can recognise things...I get very angry at times...There's no easy answer, but I feel it has to be recognised that we can't have a universal policy. It has to be relative to the area.

This statement echoed the general concern that decision makers did not recognise that social needs vary from community to community (Chapter 8). The Minister of Education's proposed 'parents as first teachers' project also drew some comment from several nurses, including Robyn:

> Dr Lockwood Smith's got this other new project called parents as first teachers. It's a thing that we've been doing for years...The money's coming from the education fund not really the health fund, but ...people think it's Plunket. So that got up our noses a bit because all that money is going to go into that...They're talking about using volunteers. They have safety officers now... talking to the mother about the safety of her children and of the home, which we do along the way anyway. People get so confused by all these people doing all these

> wonderful jobs...Perhaps we're protecting our jobs a little bit, but mothers have got so many things going on in their lives when they've got kids.

Although participants were concerned that aspects of their work would be done by people who were poorly prepared and that the number of outsiders involved with families would increase, not all of these changes were viewed negatively. For instance, there was approval of moves towards more clerical assistance (see below).

A Changing Contract

The current contract between the Plunket Society and Government included drastic cuts in the number of home visits required of Plunket nurses; a reduction in the total number of consultations; a reduction in the detail of some of these consultations; and a reduction in the time span of a child's life that Plunket nurses were required to monitor. The cut in the number of home visits during the first three months of an infant's life was a recurring topic. As discussed in earlier chapters, nurses stressed the importance of their initial visits to a family. Susan voiced the general concern:

> The Government and now the Plunket system will only allow me nine visits (total). If I've got a family in crisis, or only generally just surviving, I could have done nine visits before three months is up...Nine visits is nothing...The volunteers pick up another four visits for me.[4] That's invaluable. I couldn't do without them.

Lynn spoke at length about the new contract:

> ...nine contacts with a family with a child between the ages of two weeks and three and a half years. That is quite unrealistic for the majority of parents—first time parents, for example. You might as well not be there if that's all the contact we would have. The argument is that it allows the nurse more time to spend with at risk families. Up to a point that is right, but I can see these sorts of contacts at the rate it's going will be less and less. I just can't imagine what the service will be in the future. It's so dramatic, that change. I think we probably have seen people (too often) in the past. I don't deny that, and I think because we've done that, we have made families in some situations incredibly dependent on us. I believe that public health nurses unwittingly assist in that some clients see that service as easier for them because public health nurses continue to visit at home until the child is five years old. This is necessary and logical in some families, but there have been a number of people who do have the resources and the facilities to get up and go to clinic, but they have seen it as easy to sit at home and have someone call...I would love to see a situation where a Plunket nurse and a public health nurse worked together with those families who had the greatest need. The public health nurse could look after some of the other issues like school age children. But working as a team ... would work better.

Some of the major themes within the responses were implicit in this statement: the concern about creating dependency; the importance of contact in building a

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[4] Volunteers were beginning to pick up some of the more routine aspects of Plunket nurse work, but the interviews did not draw enough comment on this to enable me to write at length about it.

relationship; a changing approach towards more flexibility; and a preparedness to work more closely with other health workers.

Much of the nurses' ambivalence to the changes they were experiencing centred around the trimming of their nursing service. Government cuts to Plunket's funding meant fewer consultations but fewer consultations were part of Plunket policy and were consistent with the nurses' goal of discouraging dependency. Even though they all stressed that regular initial visits were crucial to the quality of their work, they also stressed the importance of helping people to become more independent and pro-active. Philippa, a more recent recruit to Plunket nursing, felt positive about the reduction in the number of consultations:

> The number of visits and the number of clinics seem to have been drastically reduced. Now a lot of us had been trying to work on a "You come as often as you need to basis," to try and cut down this dependency on too many visits that were not necessary. And explaining the service, so that if you needed to see the baby weekly for any reason that the client understood that...So for some of us that didn't mean too many changes to our way of practicing anyway, but definitely the source of those particular changes was money.

At the same time that there were cuts to services and to nurse numbers, changes within the contract allowed Plunket nurses more flexibility in their work. Depending on how they were implemented, these changes allowed for more autonomy for the people using Plunket services. Formerly, Plunket nurses followed a rigid schedule of consultations that remained unvaried regardless of need. At the time of the interviews, there was a minimum number of consultations required, but there was also sufficient flexibility within the contract to allow a nurse to increase the number of consultations according to need, as determined by both nurse and family. Trish commented on this:

> The priority register is really good. It gives us as many visits as we'd like on those people (with greater needs). It keeps those ones in your mind, and you've really got to work on a good relationship with them. You can put more time into where it is most needed.

Thus while the nurses were upset about the cuts to visits that they saw as needed, they appreciated the increasing flexibility allowed them under the new policies, and they welcomed the freedom to give more time to people with the greatest need. The nurses own perceptions were changing in ways that, to a degree, were concurrent with retrenchment forced on them by Government. As Robyn said:

> There's lots of people out there that can manage very well without close supervision. We were over-supervising...(Now) our contract starts at ten days with five visits required in the first three months, but we are allowed to adjust that, (so that) the priority ones will get more than five contacts.
> ...I think that has been well worth doing, because a lot of people only came because it was the right thing to do...People look on it as much more important to visit if we spread it out a bit more, and it's worthwhile because they keep their appointments.

Measures were taken to compensate for the reduction in consultations given by Plunket nurses. For example, nurses made their scales available to parents who wished to check a child's weight, and they ensured that people knew who to contact should a problem arise. At least one nurse kept her clinic open for one afternoon a week on a drop-in basis. They were developing a wider variety of options.

An Increasing Range of Services

In the course of the interviews the nurses talked about the range of services that they were now offering. These included open clinics, screening of pre-school children, group education for parents, and programmes within schools.

Working with Larger Numbers of People

There was already a trend within The Royal New Zealand Plunket Society for nurses to become more involved with group screening and group education, and now within the current contract there was the requirement of: "15 hours of post-natal parenting education to 7,000 caregivers with children under 18 months." Group work was carried out in a variety of ways, and included open clinics, screening of preschool populations, parenting classes and support groups.

Open clinics were usually held in halls and involved children being screened by a number of health experts. Health education material such as pamphlets, books, audio-tapes and videos were made available. As described by Robyn, attending an open clinic was not unlike attending an exhibition with the exhibits arranged in a set order:

> You involve other people like the local dental nurse, and the hearing gets done, and a guy comes who's an optician...He comes voluntarily and does all the kids eyes...They (parents) get a form to fill in and they tick off anything they're worried about. You discuss that with them. You can put them through pretty quickly, but it is quite exhausting...I think the open clinic for older children is positive. It's good public relations. It's good team work. It's good to work with the volunteers. It's a good health day.

At an open clinic, the Plunket nurse, as the last person the family sees, can follow-up on any problems. Robyn also pointed out that even though appointments were not made, the wait and time involved for people attending was less than it would be if they saw all of these health professionals separately.

Most of the nurses spoke of their concern that their last contact (under the new contract) was when a child was aged three and a half years. They were also concerned for children whose families had opted not to use the Plunket service. Wendy, like many

of the others, talked of catching up: "We've started doing three year old checks again. We've got our first one next week [with] thirty children. We've started alphabetically." She also mentioned that Plunket nurses were beginning to work in pre-schools, but added that she did not know how widespread this was. I found that some of the nurses in the study had been involved in this work for some time.

A pre-school clinic followed the same pattern as an open clinic, with parents invited to attend, with a number of health workers offering their expertise, and with the Plunket nurse acting as coordinator. Participants working in areas where public health nurses were still working with children from birth to five years did not have the same involvement in pre-schools as those working in areas where public health nurses had withdrawn their services six or seven years ago. Noreen described how pre-school screening evolved in her district:

> We were doing each kohanga reo as an individual session, but this time she (Maori health worker) had six kohanga reo come to one kohanga reo. Fortunately, they had one big room that we could use, and they all came in half hourly intervals. That was a pretty hectic morning...We have two people testing eyes, two people checking children, somebody testing hearing and somebody weighing and measuring. We have all these little stations and they move around each station. We did try these things as a big community thing in a big hall, but we didn't get the response...It was after that that we started moving out into the kindergartens and kohanga reo.

Thus screening at pre-schools emerged as another form of open clinic. In running these clinics, Plunket nurses work in close cooperation with other health workers.

Formal education for parents was varied. All nurses were either involved in running parenting courses of some kind or felt pressure to do so because of the requirement in the contract. Robyn described how the contract requirement was being met in her district:

> We have one nurse that organises these (classes for parents) one morning a week in lots of sub-branches...We have 10-15 mothers who come for ten sessions. They pay $10.00 for the whole folder and a lot of it is just basic common sense; child development; wellness for babies and children; quite a lot about their own health; family planning. We get speakers in.

Parenting classes could occur in conjunction with an open clinic or could be offered separately. In the district in which Noreen worked there was a policy for parenting courses to be taught by a Plunket nurse and a Plunket volunteer working together. As well as courses on parenting skills, nurses were organising play groups and support groups for parents. However, there were difficulties.

The Difficulties

Offering group clinics and group education freed the nurses to give more individual support where the need was greatest, but the change from working within a family to working with larger groups of people was not easy especially without preparation. Additionally, people expected a personal service from Plunket nurses (Chapter 8). Robyn described her experience:

> The open clinics were a big change. The first one—oh, it was the last straw! I never wanted to see another one, but we got better at them. The committees and the populations got better at accepting them and it's going along quite nicely . We'll probably carry on with them and have four or five a year .

Adding to the difficulties, the contract required a commitment from parents to attend group sessions. This was of major concern to many of the nurses, Hope included:

> You haven't got the energy for fighting...the stupid ridiculous stipulation they have put in. No thought has gone into that. What mother can commit herself to fifteen one and a half hour sessions?...It has to fit their numbers game...What one mother can learn in an hour, it takes another mother, be she 15 or 35, ten hours to learn it. You can't put everyone into little boxes and say they all must have this. Everybody's different.

Susan also talked about 'a numbers game,' and Philippa saw the possibility of the emphasis on numbers rather than quality of service as leading to an erosion of professional autonomy and accountability to the people using her services:

> What really upset me...is that they were beginning to look at the job in terms of numbers...It was not giving the flexibility to put more energy into areas of greater need ,and it could easily lead to a dishonesty of practice. If you know that the community that you work in isn't going to be interested in group education, you are only going to ask people to come who will come, whereas in fact those who don't come are the ones who need more one- on-one time, but you are not going to get the opportunity to do it.

The emphasis on numbers detracted from the potential for flexibility. Mary, who approved the change towards more group work, had doubts similar to Philippa's:

> I think the trend towards education, that's what they're really stressing at the moment, is a good thing. It's beneficial for women and children, but I think its not targeted right. People who are motivated to come to a group are not the people who need the information. They know how to access it anyway . I resent that you spend time with people who can access the information for themselves, whereas the ones who do need it are not the ones who feel comfortable in that group situation.

As Philippa stressed the importance of flexibility in running successful groups, she said, "[Flexibility is] going to become a really important aspect of Plunket in the next year or so. There **must** be flexibility, and I don't know if it will be included." Flexibility and tolerance emerged as qualities in the nurses' own practice as they talked about how they ran groups for parents, and how they resolved some of the difficulties noted above.

Resolving the Difficulties

Moving from working with family members to working more with larger groups was stressful. Mary's experience and reactions to the policy on more group work paralleled that of most of the others: "I felt that compulsion from government policy...It was really really stressful...It's terrible." Mary said that after her Principle Nurse told her not to worry about groups she felt more relaxed. To her surprise, however, she ended up with a group and was pleased with the results:

> But I didn't do it because I had to. It just happened that there was a new mother who was a registered nurse who was really motivated, and she was prepared to co-ordinate the group. I gave her a list of options of speakers. It evolved out of my work, and it met the criteria. There were ten women in the group and there were ten sessions...It worked really well, but I don't know whether I would have done it if I'd had to.

Despite Mary's reservations about group work, she saw that the women who participated, benefited:

> It was really a middle-class group, but in a way they were anxious...great needs for support. I felt if I didn't get them together they would be constantly draining me, because they would be wanting me all the time, whereas now they've got that group together and they get support from each other.

The process that Mary followed did not involve a lot of her time.

> It's a thing that a nurse doesn't have to do. All I did was get them together, ...offered them the option of forming a group and then gave the list of names to someone to ring around...It worked. They met for a few weeks and they got to know each other. Then I said to the group, "Here's a list of people who might be interested to talk to you...If you want me to organise anything just let me know."

Susan worked in an area where most people were not motivated to attend groups, and thus could not expect group members to help with organisation. However, she saw it as important to bring women together: "I think it's very positive. It gets mums...together, meeting each other." She didn't hesitate in beginning group work, but she didn't find it easy: "It takes a lot of work and energy... If it's going to go smoothly you can be sure that a lot of ground work has gone into it." She talked of her efforts to get people to attend. How on the day she would remind them: "They'll say 'Oh, is it today? I thought it was next week,' and they'll come. And it's great."

Because the nurses found that attendance depended on how comfortable a particular group felt to those involved, they adapted their work accordingly. Hope was among those who talked about working with a group of very young parents:

> Because we saw so many that age we had to provide something where they could feel comfortable. They don't feel comfortable in a group where the mums are talking about their Taupo holiday or their boat or whatever. In some ways it can blow you apart a bit hearing them...discussing...where they get their drugs; who's the best social worker to deal with; how you can get the most out of the

> system. It's quite different... A year previous most of them were at school getting told what to do. I can't come in heavy at all. I've got to get alongside. And I do. I really love those young parents. If I didn't really care for them they would soon just tell me to stuff off. I wouldn't be around. They don't mince words. So I have to get alongside them and they have court cases to go to and custody things to deal with and drugs to get off and different set of problems from what you come across with another age bracket. It's rewarding in itself but very tiring.

This statement of Hope's serves to recap much of what was said throughout the interviews. Both caring for and avoiding a one-up position in order to be alongside service users were seen as essential to a positive outcome.

The nurses were running a wide variety of groups. They talked about trial and error—about one group not working in one situation, but working in another. They talked about the numerous topics they covered. Topics which included parenting skills, child development, basic health requirements, contraception, self-esteem, self-care, ante-natal and post-natal topics. In their responses the nurses revealed their own initiative and flexibility.

Changes Initiated by the Nurses Themselves

Have you brought about change at any time?

- *If yes, how have you done this and how successful do you think you were?*
- *If you haven't been involved, but became involved now, how successful do you think you would be?*

As indicated above, all of the nurses interviewed were very involved in the changes that they were experiencing. All had contributed to change at both the practice level and at the national level. At the national level, in 1992, all nurses had co-operated to present two submissions to the national executive. Noreen said, "We...stood together to lobby the Plunket organisation and I can see nurses taking a stand again." Philippa when asked if she had contributed to change, replied:

> Yes, and in fact we all did with submitting ideas ...The problem with the Plunket Society is that often change is foisted upon you without any consultation. So suddenly the policy was made and you were expected to implement it, and what (we) were trying to do was to get more two-way communication.

To stand up to a powerful organisation can take courage, and someone who does speak out can be seen as threatening. Mary had the experience of others trying to silence her:

> You can say your piece and I do, but I don't feel that I get anywhere. Then you get the odd comment from your colleagues...I've said too much—rocking the boat... then there's a comment like "You don't know the history of this," and I

> think, "Oh, I don't know. I'd better shut up...I get hot under the collar about it. These nurses, you can see them visibly shrinking back and you can make these statements and you turn around and there's no-one behind you. It's amazing that they all feel strongly about it, the hierarchy, but they don't feel strong enough amongst themselves to stand up together and say something about it. I think they've been reprimanded too many times...It's particularly bad in Plunket because you work on your own. There isn't a chance to talk about it in the course of the day.

Silencing can come from the top as well. At the time that I was negotiating to do this study, there was a ban on people working for The Royal New Zealand Plunket Society talking to the media. This was not helpful for Plunket nurses, like Philippa, who would use the media to advantage:

> What we did locally was work with others, who are involved in the area of health and education...on ways of breaking the poverty cycle in New Zealand... (However) there was a ban on us talking to the media which I think would really have helped...It was pathetic.

A very visible change was that from Plunket nurse in uniform to Plunket nurse in mufti—a tangible indication of a health professional moving from a position of authority to a position of equivalence. It seemed that the nurses themselves had demanded to be out of uniform and that the transition had been gradual. Lynn commented: "In 1985 we were only wearing uniforms in clinics. By...1987 most of us were out of uniform full stop. We weren't meant to be. We just refused to wear them." Lynn added that not wearing uniform had removed a lot of barriers, and Susan observed:

> I find that in my particular area it would be off-putting to my clients. I am going in on their level. If I'm wearing a prissy fussy badge encrusted uniform their perceptions of me are going to be different...I am a firm believer that uniforms in the situations where I work is down-putting for the client, and I am not there to do that.

Several nurses talked about the changes in the philosophy and the modes of Plunket nurse practice as originating with the nurses who organised their preparatory Plunket course. Fay illustrated this as she talked about the Plunket course she had taken:

> They (the changes) were being instigated at that stage. So really the changing in attitude, for me was already installed...There was a lot of focus on 'This is how Plunket was: we were known for coming around and weighing the babies. Now that's not how we want to be known. We're not there to weigh babies. We'll do that, but that's not what we're there for'...so therefore the going in weighing the baby and telling the mother what to do next, how she should be washing, wrapping, changing, that doesn't exist, it doesn't happen. I mean you point it out that you better check these sort of things when you are washing baby, but these things are only discussed if it's warranted. It's not discussed otherwise.

Kate, talking about her perception of the way Plunket nurses have tended to work, said, "We were the ones who said, 'You do it this way,' and the mother would do it or she wouldn't let on." Wendy affirmed that the focus of Plunket nursing had broadened:

> When it (Plunket) was first set up it used to be just the mother and the baby. You didn't become involved in a wider way with the family...Now it definitely does encompass whole families and not just the mother and father and the siblings, but even to grandparents and aunts. You are looking at that extended family to see if there is support there, and very often it will be the grandma who will come to you because she perceives a problem. It's much more natural. It's how it should be.

As she talked about how regimented and narrow Plunket had been, Kate was in agreement:

> They didn't work with the family as a whole. They tended to work with the babies. They didn't even work enough with the mothers...They didn't see all that the mothers contend with...That part has definitely improved , and now students going out with the Plunket nurses find it really quite interesting...Now there's so much that a Plunket nurse is doing in relation to clients and families. She sees the whole family, the extended family. She sees what happens with all of them...I think it is a really good service now...I think we are improving on it all the time.

Again the changes described include a broader, more flexible mode of practice. Wendy and Noreen both mentioned flexibility in terms of home visiting. Noreen said: "I have got quite a few young mothers who have difficulty getting to clinic. I'm flexible too, with people with twins; with people who have to walk with more than one child. They would be visited longer." Because of their commitment to the people using their services, nurses had begun adjusting their schedule of visits according to the needs of the families they were visiting, **before** the contract afforded them this flexibility. Fay was one of these:

> I agree with the reduced home visiting. In fact, I had already started changing my home visiting. I didn't see the necessity for me to go in to see a mother of three competently caring for her children. I didn't need to go in every week and check on her, and that's really what she would have felt. She could contact me. So I'd already cut that out...but if I've got a mother who's not confident, who has a small sickly baby, I will visit once a week or twice a week if I feel that's necessary. And I'll continue to do that whether they (Government; Plunket) want me to or not. I'll do it because I see the need for it.

Fay also talked about how she coped with changes in the contract that she found constraining:

> You can't make it across the board for every area of New Zealand. You can't say ...the parents must come to the clinics. That works beautifully in some areas...It's very difficult to get that to work in my area...But they're not recognising that in some situations it has to be done differently. We are not given those options...What I do is I give them an appointment. They don't come...I'll ring them up and say "You've forgotten, can you come." Yes they will, yes they had forgotten. Or I'll drop a card in their box, "You forgot. Could you come next week?" very often they will. But if I've got a mother (living a long way from the

> clinic) and she's had her fourth child. She's got no transport, no phone...I don't even expect her to come down. I don't expect her to come to my clinic and I won't even invite her. I'll tell her about it, "Do you think you'll be able to make it?" " No," and I will make a visit to them. I'll bring all the files with me and I'll check any one, go through any problems. That's what I do. So I know my area and I will continue to make home visits...I need to be sure in my mind that those children are well, that they are developing normally, that she is OK...It's up to me... I've got to make it interesting and I've got to make them want to see me. There's nothing that Plunket can do to alter that. That was very much my job...it's essential.

Fay was not the only one who talked about continuing to visit at home after the contract required that people attend clinic, but what I have quoted here was the most graphic description of these continued visits and some of the reasons for them.

Combining the theme of the constraint of inadequate policy with the need for professional integrity, Beth advocated the importance of accountability to service users:

> To adhere to a policy that is not right, I can't really do that, because I think I will betray people...It is not that I don't want to co-operate, but I think that in a lot of cases it is actually the wrong thing. I learnt a hard lesson when...I helped provide for a playgroup...It was going well. It was just before the kohanga reo came in. The Plunket rooms were right next door to the marae and we had good rapport and the Maori ladies of the marae came to us to see if we would like to come and help them (with a playgroup). Then my previous boss heard about it, and she said that I could not spend any time that was outside my brief...So I had to say to the people that I couldn't come any more. I didn't have the courage then to say I'll do it in my own time...So it all folded because the people in the playgroup hadn't got the skills and the Maori people were just embarking on something new for them...and it all fell flat. (It) would have been a wonderful achievement if we had just kept on working together . We were really making a tremendous break through in that community. And that's why I say if policy is not right sometimes you have to trust your own insight more than policy and just revolt and say, "Right we'll do it this way."

Beth had since begun another playgroup, but not in Plunket time. This action was also an indication of a commitment to improving health as well as of evidence of involvement in the changes that were occurring at practice level. The actions of all nurses were accelerating the movement towards a more flexible service. As a further example, there was a nurse who ran a clinic on a drop-in basis one afternoon a week: "I haven't even told the boss about that. I probably should put something in writing." Noreen made the case for professional autonomy resting on the perceived need for flexibility:

> We've got an area with a case load and we are supposed to look after that. I think that we should be able to work that case load any which way that we decide to do it, provided that we are seeing them (infants) at the required times that we are told.

Throughout the interviews, 'change' was often part of what was being said. The nurses could not avoid being involved. From their responses their involvement was both

adaptive in response to a changing situation and pro-active towards the goal of a better nursing service. Frequently, their involvement was far from passive. Fay said:

> What you can't change, you can try (to change), and we'll continue to try. We wont give up. ...If it makes me angry enough I will sit down and write something, or I'll say something, or I'll do something...Maybe we haven't been pushed to the point where it's **that** important, or **that** threatening that we can't cope with it. And I guess if it were **that** threatening or **that** essential then we would do something about changing it...If I was told that I was no longer to do home visits, that I had to run all my things from the clinic, I would really do something. I might as well give up because there is no point in my area of doing that.

Although Fay remained satisfied with the outcomes of her work, she went outside of the contract to achieve this satisfaction and she was feeling the pressure. Another nurse appeared to be under even more pressure as she talked of reluctantly moving beyond the contract:

> The changes (in the contract)that we've made this year...We are not setting up the ideal relationship with only doing two home visits...I don't know some of my mothers now. I have to look at them when they come in (to clinic), and I think "Well who are you?" I can no longer put in the amount of time necessary for developing a trusting relationship, and to me that's bad. I'm about to visit at least one more time more than what anybody else is going to be told about, simply for my own relationship process...You are told to visit them once and leave them a couple of weeks. You can't. So I'm going to visit them the following week and hope that nobody finds out.

As Fay continued to talk about change, she revealed that in her area Plunket nurses worked together and thus were able to support each other. She also expressed excitement at the thought of participating in change:

> Change is often initiated by nurses...We've all worked towards change. Towards more efficiency: group clinics; organising support groups for example for young parents. It's particularly difficult when there is no committee. We work in pairs, support each other more and we are offered wider staff support...I feel quite excited about change, it makes life interesting. I see it as a challenge. Not as necessarily detrimental. If we can use it, we could offer a damn good service. I'd like to be in there helping to organise it.

CHANGES THAT WOULD IMPROVE THE PLUNKET NURSING SERVICE

Are there any changes within the Plunket organisation that could be made that would help you to improve the service that you give?

When the nurses were asked about changes that would help them to improve the service that they gave they proposed a number of measures, many of which related to more than one constraint. For example, an increase in the number of Plunket nurses would enable caseload numbers to decrease, therefore nurses would be able to meet their desired standard of practice more readily, stress levels would perhaps decrease and

job satisfaction probably increase. With only one nurse addressing problems of understanding in relation to policy makers, it seemed that in this part of the interview either they thought only in terms of their practice or they felt helpless in the face of the structural problems within Plunket. The tone of the suggestion that **was** made (that if Plunket managers spent a few days working as a Plunket nurse, they might understand the work of the nurses a little better) suggested the latter.

The following discussion of changes that could improve the Plunket nursing service is organised under two broad headings, beginning with suggestions that related to changes in social structures at the practice level, followed by ideas about more support for Plunket nurses.

Different Structures and Resources at Practice Level

In everyday language, there tends to be a dichotomy drawn between large institutions, such as prisons and hospitals, and the community which uses and works in them, even though these institutions are very much a part of the community. This particular dichotomy allows for denial. That is, people who are sick, dying or have been found guilty of committing a crime can be seen as 'not part of us.' The separation of hospital and community can also contribute to certain people taking very powerful positions. Susan discussed a communication problem with some hospital personnel which prevented her from working as effectively as she would like. As a remedy she suggested a formal integration of hospital and community practice:

> If we start regional planning now, and this hospital was brought into our community...If they actually came into our community and worked with us and for us and between us, that would work. I think that would be a very good system. That would be what I would push for...Once we really get going in a group situation, a community situation, I think it would be a lot better for the client and we would appreciate each other far more than we have done.

Robyn saw restructuring at the local level beginning to work in both the Plunket nurses' and the public interest in terms of bringing more resources with it:

> I think the time will come...when a lot of little sub-branches will be closed...They'll have the family centre and the main clinic and decent facilities for groups and things like that...They 're talking about getting a caravan and going to the suburbs in a caravan or a bus. It's got to come to that really, because the upkeep on these clinics is high....They might only be used once a week or once a fortnight.

A caravan can help to improve access to services: for a person at home caring for an infant—caring for several very young children, with no security about housing, no food in the house, no access to transport, and 'enjoying' minimal social status—to get out

and attend a class is a big step, even on a fine day. A mobile clinic would help, but as Susan pointed out a van would be even better:

> I would like to be able to provide a community van for my particular clients and share it amongst five workers. That would be incredible...if I had it one day a week in my practice then other people could have it other days... transport is a major thing in the area where I work...On a rainy cold day how are they going to get to the clinic...I could put up with dirty rooms, I could put up with no help at all, but I would love a community van...That would be wonderful.

The transition towards more group work brought problems related to resources and personnel. For example, showing overhead transparencies, videos and movies required more space and special equipment. Organisation for group work took time and energy. As they worked with increasing frequency with larger groups of people, nurses were finding resources to be inadequate. Susan was one of several nurses who requested more facilities and more help:

> So there's quite a bit of equipment I would like and quite a bit of help I would like. If I'm running a group, it takes a lot of time and energy and I like it to run smoothly. I like it to be right. I like the women to feel comfortable and therefore I really need another helping hand but I'll never get it.

Beth, thinking of the playgroup she was running in a primary school, could also see a need for more resources:

> I am happy with what I am doing. The concept of parents as first teachers is much larger than the Minister (of Education) realises. It would be better to have the money spent on setting up centres of **health** education in schools. It would be better if in areas with Polynesian and Maori populations more local people were involved as health workers and we could work closely together and share our information and skills.

Similarly, Philippa requested more "culturally appropriate health workers and more team work. She was interested in larger health centres incorporating a number of different services:

> ...more money and more nurses and more...culturally appropriate health workers ...I'd love to see more family centres...like the health units they have in Britain, where they have a midwife and a district health visitor and a doctor and a social worker etc etc. So it is a big team in that community, and they all know that community and it's needs, and they all know where they fit in the scheme of things.

In summary, when asked for suggestions of measures that would improve Plunket nursing services, the nurses proposed structural changes, as well as increases in resources and in ethnic variation in Plunket personnel.

More Support for Nurses

When they talked about more facilities for educational purposes, several nurses mentioned someone to help with the organisation of groups (mentioned above). In addition to extra pressure on time, Mary felt her lack of skill in producing teaching aids: "It would be really good to have someone to do the art work for you...If I want to do a poster I actually have to stress myself out and do [it] and take [it to be] laminated." With increasing responsibility to run classes or meetings, nurses were increasingly finding themselves doing non-nursing work.

The question of paid clerical support came up several times. As Mary pointed out only the nurses can write the confidential family notes and reports, and the statistical data did not take her a lot of time to record—five minutes a day and between half to one hour at the end of the week. However, for many it was not an easy task at the end of an exhausting day, and senior nurses had to spend a more significant amount of time compiling the data as it came in. Wendy suggested that a clerical assistant could do this task instead of the senior nurses without violating confidentiality. Wendy liked to be organised and she had a streamlined system for recording statistical data:

> We all work different systems and I've got ...a really neat little book that I keep all my new cases in...All the information that I need for the whole year. So I don't need to look at a chart. All I need to do is open up my new baby case book and I've got the number of new babies, whether they are breast fed, when they were weaned and put on the bottle, whether their vaccinations are up to date, (etc)...I've got it all in that little book. I don't know if everybody works like that, but it's good from my point of view...Quite a lot of the work that we did could quite well be done by people who didn't have any medical knowledge.

One of the senior nurses who did have some extra clerical help from a Plunket volunteer said how helpful this had been. Even to have someone to do some photocopying (which required a trip to another agency) was appreciated.

Although, because of local structure and philosophy, some nurses were able to support each other more than others, most expressed a need for more support. Even though Kate worked from a shared base, there were problems:

> It's one of the dangers that we are all working separately. We try and meet (weekly) but ...a nurse will come in from her daily rounds and clinic and there will be no-one there and she will go home. Often that nurse really needs to talk something through. (We need) more support for nurses.

The everyday work of a Plunket nurse is exhausting and can be very stressful. There are times when nurses are working with families in crisis, experiencing catastrophe and tragedy. Cot death, for example, is profoundly traumatic. From the nurses accounts it appeared that the need for on-going supportive supervision was very real indeed, and that there were times when this kind of support could be crucial. Many talked about

how stressful they found the work when they first began it (see previous chapters). Mary, looking back on her first year with Plunket, said:

> I didn't want to get up and go to work in the morning. Just really stressful. A really awful year. But now I think it's good. Now I think I can carry on and do this job. I've got over it...It's like being thrown into this big diving pool and being left to sink or swim. Whereas we could all swim if we were given a bit of help.

She continued:

> I saw someone else come who'd just done the Plunket training and who was younger than I was. I suddenly felt all this compassion for her. I knew what it was going to be like for her, and I realised I'd come a long way which I hadn't realised fully before.

Also, change in itself can produce high levels of stress. Kate talked about this in relation to a changing mode of practice:

> It's the nurses who find it quite hard to make these changes...The nurses are natural nurturers and I think we hang on. We take all these mothers and we create dependency. It's very hard to give that up (but) I think that nurses are getting over it...(It) has been quite a major problem.

Besides, Plunket traditionally had required a rigid and more frequent schedule of consultations. Robyn talked of the difficulty of cutting back on visits to a mother with her first baby, even after she had said that she could manage, and knew where to ring if she couldn't: "It is a guilt thing...Because for so long it's been so rigid." Mary expressed concern about support for nurses working in a changing organisation:

> You need a lot of support; especially through the change process. I don't think there's any facility to support that. We need a supervisor. There's a senior nurse position, but that's a very busy position. There's not enough people to sound ideas off. You end up being so tired that you can't be bothered.

Finally, describing the difficulties a sick Plunket nurse faces, Noreen asked for: "Proper back-up—a reliever for when nurses are sick. So that we don't have to cancel twenty odd people and have to make new appointments for them, trying to fit them in when we are booked up for six weeks ahead. An awful lot of Plunket nurses work when they are sick." In all of these situations—making a start with Plunket nursing, coping with change, coping with crisis, personal sickness—support is critical.

SUMMARY AND DISCUSSION

Threats posed by retrenchment to the quality of their work and the contract requirement of 'parenting education' were what seemed most pressing for the nurses in both this and the previous chapter. Cuts to the number of home visits made in the first

six weeks of an infant's life were of particular concern. Nurses spoke repeatedly of the importance of these visits in building trust. Although the current contract offered them more flexibility, the nurses continued to be constrained by increasing workloads and the overall cuts in the contract.

In the past, Plunket was characterised by a rigid structure and values which centred around authority and control. This system offered a great deal of security to those who complied with it, but to step outside of the rigidity and rely on trust rather than authority could be difficult. The transition from authority to trust is exactly what the nurses in this study were involved in. They insisted that parents can look after their own babies and their goal was for families to be more self-reliant; more in control of their own lives. They stressed the importance of a flexible service in order to meet the diversity of needs. They gave many instances of the ways in which their work was changing: their increasing flexibility in the way they scheduled their visits; the number and variety of groups that they were running; their increasing co-operation with other health workers; their vision of parents as the most important authority on their children.

Along with a changing practice, there was the increasingly positive relationship with other health workers. This appeared to stem from a number of factors, including changes originating with the nurses themselves as well as changing attitudes towards Plunket (Chapter 6 and 8). Plunket nurses were no longer the 'Cinderellas' of their profession. Robyn remarked : "It's only in the last few years when nurses got much more assertive. We've always had good education, but people are beginning to realise that we are a great source of knowledge." Plunket nurses were respecting and valuing themselves more than they had in the recent past. This in itself invited respect from others. Furthermore, as the nurses worked more closely with other health agencies, they learnt more about available resources. Furthermore, because of their approach (Chapters 6, 7 and 8) they developed a sound understanding of the social realities of those who lived in the areas in which they worked. Consequently, they were beginning to be seen by other health workers as persons holding information of value.

A striking feature in this as well as the previous chapter were the nurses' unfulfilled needs for support. Regardless of the pace of change, the work of Plunket nurses is stressful. As the pace of change increases stress levels increase. Furthermore, deep-seated traditional feelings of responsibility increase the discomfort felt in cutting back on services.

Although Plunket nurses appeared to have been powerless in the past, they were beginning to assert their collective voice. They insisted that their work addressed the various needs of those seeking their assistance. Despite the demands placed on them by the Plunket contract with Government, they shaped their work according to their professional standards and goals. As Wendy said: "We can't go back. The Plunket

service will never, ever be the same as it was even two years ago. In many ways what has happened should have been done years ago."

In this chapter, I found that to identify the origins of the changes the nurses were experiencing was not a simple task. Many different agents were involved. Fraser (1984:67) wrote that answers to questions about how and why a particular social system developed are 'ongoing' and 'hotly debated.' However, he recommended the four approaches (enlightenment, necessity, action, and power) suggested by Abrams (1982), and it is possible to apply each of these approaches to the changes I have described in this and previous chapters. For example, enlightenment theory covers the pressure of public opinion and the influence of international fashion in thought. The latter was apparent when the nurses talked about new perspectives on primary health care and health promotion. Their responses suggested that they found these perspectives compelling, and that they shaped their work accordingly. They also felt the pressure of public opinion as they faced people who wanted the Plunket service to remain as it had been.

Necessity theory accounts for responses to need. The emphasis on a service flexible enough to be appropriate to needs which vary according to demographic area, (from household to household even) was constant throughout the interviews. Responses revealed a high level of awareness of social diversity, and offered examples of response to various and changing needs included visiting people at home when their circumstances precluded them from attending clinic, and organisation of groups in particular ways in particular venues to meet the needs of particular people. Overall, the nurses referred again and again to more flexible Plunket nurse practice adaptable to the diverse needs of service user groups. Their responses presented a clear picture of service providers accountable first and foremost to service users (Albee 1980).

Action theory allows for the effect of conflicting interest groups competing to achieve their own goals. Within the Plunket organisation this was most marked with the conflict between Plunket nurses and volunteers highlighted in Chapter 6. Also there appeared to be a history of conflict between the Plunket Society and the Department of Health, surrounding infant welfare services (Raffle 1977). It seemed that this conflict was acted out at the level of practice as well as at planning and administration levels (Chapters 6 and 8).

Power theory subsumes the above three theories and offers an explanation of why some instances of the above are successful and others are not. Fraser (1984:69) argued, "For it is the power that is mobilised and applied, that proponents of this approach would argue, is decisive in both the formation and implementation of social policy." From the nurses accounts they were not in a position to mobilise or apply power. From

their perspective their submissions to their executive in 1992 were ineffectual (Chapter 8).

Together these four theories act as a useful framework of analysis, but still something is missing. The nurses themselves appear in enlightenment theory as they react to need, and in necessity theory as they respond to new ideas and to public pressure, but the role is reactive. The ways they change as a result of their responses are lost. In action theory they do appear as initiators and actors, but in power theory, having no place in the power structure of Plunket, they have been completely absent. Perhaps what is lost could be called 'process' or 'links.' For example, some nurses have reacted to the increasing despair, anger and stress, that they are witnessing, by seeking further skills through taking counselling courses. By taking these courses they begin to experience a change in their own attitudes, as well as an increase in communication skills. These changes in themselves must in turn create change in the people with whom they are in close contact: people who use their services, people who hold more power than themselves within the Plunket hierarchy, and other health workers.

When I first read about the four approaches offered by Abrams, I wanted to add a fifth, namely the power of the dominant narrative (Chapter 1). The dominant narrative takes on a power of its own, dictating the musts and shoulds in the lives of the people who have assimilated it. Its words become part of what could be called the landscape of consciousness (Bruner 1986:14). Until the end of 1992, it seemed that Plunket volunteers and the medical officer within the Plunket executive had the power to write this narrative for the nurses. But increasingly the nurses have, behind the scenes, been writing their own narrative. In their responses they insisted on the importance of working in ways that were effective, regardless of the agency's requirements on them. As well as working according to their personal and professional values, and covertly developing a dominant narrative of their own, they were now finding a collective voice (in the form of submissions to their executive) to influence the narrative overtly. And they had some hope that the recent restructuring of their executive body would now allow their voices to be heard.

Part Five: Conclusion

CHAPTER TEN

DISCUSSION AND CRITIQUE

I began this study with two broad objectives: one to record the standpoint of Plunket nurses; the other to investigate change within Plunket nursing. My interest in the former originated from reading a number of books and articles (for example: Schaef 1981; Smith 1987 and 1990; Haraway 1988), which supported my own experience of one dominant voice in the academic literature. Consequently, my aim was to research a standpoint which was not well represented ('Introduction' and Chapter 2).

The reasons for the second objective were embedded in my feeling that the practice of Plunket nurses had been changing since 1980. Plunket began with a set of defined standards which nurses were expected to enforce through their contact with mothers (Chapter 1). In general, Plunket nurses worked as agents of social control. From personal observation, I concluded that Plunket nurses were on the whole becoming less authoritarian, more supportive of families and more flexible. That is, within Plunket, the relationship between service provider and service user was changing.

FINDINGS IN RELATION TO OBJECTIVES

Standpoint

The first of my objectives is met in Chapters 3-9, in which I begin to establish the standpoints of the twelve Plunket nurses whom I interviewed. Given that these people were generally in agreement, their separate standpoints come together in a collective voice with a fundamental concern about relationship. Within this standpoint there were positions on issues that were peripheral to the key relationship which was that of Plunket nurse and service user, but which were highly important to participants. For example: the work was found to be extremely stressful and consequently supervision for nurses was seen as a priority; the health system was seen to include a wide variety of both treatment and preventive services and Plunket could be placed within it in a variety of ways (as a form of family practice, at the levels of primary prevention and primary health care, and as an organisation that linked in with all others); and although relationships with other health workers were described as improving, the relationship between Plunket nurse and Plunket volunteer tended to be problematic. All of these issues have important connections to relationship of one kind or another.

Relationship emerged as a dominant theme harmonising with and integrating the majority of responses. Of all that they had learned, the nurses participating in this study placed greatest importance on human values and they stressed the role of experience in acquiring these. They were open to learning from all situations and all people. What was of most use to them in their work was knowledge of how it feels to be in a given situation, to experience particular events and to be treated in particular ways. They emphasised the value of compassion, understanding and the acceptance and appreciation of difference. They described a nursing practice based on love, trust, respect, and humility and they demonstrated a critical awareness of the social contexts of both themselves and the people using their services. Their broad view of career as a pathway through life was consistent with the values on which they placed so much emphasis. This was also true of the underlying motivation that lead them to work for Plunket. A strong desire to see people become healthier, to live as fully as possible, was apparent throughout the interviews regardless of the focus of the questions. Although all worked at individual and community levels and could see that their work impacted positively on national health statistics, their main orientation was at the level of family practice. They stressed the value of their work in terms of support to families and thus increasing the probability of a better life for infants. "Being there, and being available at the beginning of life," was a recurring phrase.

A second major theme, which also related to all other issues, was that of 'invisibility.' Participants described a double layered problem in connection with 'invisibility': first their work was unseen, and second, their voice was discouraged and discounted within the power hierarchy. Describing a lack of understanding on the part of others as a major constraint on them in their work, they said that: some of the people using Plunket nursing services did not understand the breadth of the Plunket nurse role; among health workers (paid or unpaid), those whose work was closest to their own had the best understanding of their role; and policy makers (within both Government and the Plunket Society) did not understand either the experience of many people using Plunket services (specifically those on low incomes, those experiencing financial reversal and those from ethnic groups other than Pakeha), or the nature of a service that could be helpful for these people. This latter point was highlighted by the strong emphasis that the nurses placed on the positive correlation between home visits and positive outcomes for Plunket nursing.[1] Contact with people using Plunket services was seen as critical. Cuts to home visiting were received and interpreted with dismay. Of policy makers, "They can't see what we see", was the catch cry.

When, at the end of the study, I contacted each nurse to warn her that she was about to receive a lengthy document to read, I asked most of them why they had

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[1] This view is supported by Salmond (1975:76) and Ford et al (1990:317 and318).

participated. Several talked about seeing this as a chance to correct the distorted image of Plunket:

> I believe the work of Plunket nurses is not understood. (We are) experts in preventive health. (We are) really supportive people.
>
> The image that Plunket has (holds) is inaccurate. The more people who know the facts the better.

While not being seen and not being heard emerged as major problems for these nurses, a changing practice also appeared to be a possible reason for a distorted public image of Plunket.

A Changing Relationship between Service Provider and Service User

With respect to the second broad objective there were indications of change throughout the responses, with some change within Plunket seen as originating outside of the organisation (most strikingly from Government and from changing needs within the service user group). Nevertheless, changes in nursing practice were also initiated and shaped by the nurses according to their professional standards. The Plunket nurses in this study were open to seeing and responding to a wide range of needs, including pressures arising from increasing social deprivation. This was evidenced by: their awareness of ethnic differences and their call for a response on the part of decision makers to provide health services appropriate to need; their increasing versatility; and their search for more skills leading them to take courses in counselling and social studies.

Within the standpoint outlined above there is support for the observation that Plunket nurses are generally becoming less authoritarian and controlling in their approach to parents and that therefore the relationship between nurse and parent is changing. All participants described a reciprocal egalitarian relationship between Plunket nurse and service user as ideal, and their responses about their goals when working with families revealed an intent to establish this type of relationship (Chapter 7). It seemed that this change in relationship was initiated by the nurses. From their standpoint they worked towards establishing 'I-Thou' relationships with the people using their services, both as nurse and as teacher (Buber 1958:132):

> In order to help the realisation of the best potentialities in the pupil's life, the teacher...must not know him as a mere sum of qualities, strivings and inhibitions, he must be aware of him as a whole being and affirm him in this wholeness. But he can only do this if he meets him again and again as his partner in a bipolar situation. And in order that his effect upon him may be a unified and significant one he must also live this situation, again and again, in all its moments not merely from his own end but also from that of his partner.

As I read the above lines I think of how the nurses stressed the importance of visiting people at home. How else can they know the whole being of those with whom they work, those within the family? It was Beth who said, "You have to look not only at the child physically and mentally; the child is a whole person, within a whole family," and the others, in their responses were in complete agreement.

Buber (1985:133) writes also that the pattern of the successful health worker is the same as that of the successful teacher:

> (Healing) can only be attained in the person to person attitude of a partner, not by consideration and examination of an object. In order that he may coherently further the liberation and actualisation of that unity in a new accord of the person with the world, the psychotherapist, like the educator, must stand again and again not merely at his own pole in the bipolar relation, but also with the strength of present realisation at the other pole, and experience the effect of his own action.

Buber's outline of the I-Thou motif between psychotherapist and patient fits closely with the sphere of relation that all of the nurses who participated in this study saw as ideal. When they talked about their goals this was the quality of relation that they hoped to establish, with both the people who used their services and with other health workers. That is, they aimed to establish a reciprocal relationship, "an encounter, the one with the other and the other with the one; a genuine meeting...it involves the whole of whatever is at each of the two poles of the encounter. It is not just a part which is involved" (Geering 1983:16).

None of the people participating in this study conformed with the image of an authoritarian, dominating nurse. All expressed awareness, appreciation and acceptance of cultural difference, and stressed the need for reciprocal egalitarian relationships between themselves and those using their services.

Implications of Results

The nursing practice described in this study is consistent with the principles underlying primary health care (W.H.O. 1978:34) and health promotion (W.H.O. 1986). This places the focus on health rather than sickness. The nurses' emphasis on family and relationship also broadens their concern beyond that of the medical model which pertains to malfunctioning parts within an individual (Chapter 1). Ferguson (1982:270) writes that in the old paradigm of medicine the body is seen as a machine in good or bad repair, whereas in the new paradigm of health the body is seen as a dynamic system, as a field of energy within other fields. The standpoint of these Plunket nurses

is consistent with Ferguson's sketch of the new health paradigm. The scope of the practice outlined by participants and the breadth of their attitudes towards health was also consistent with the underlying biopsychosocial philosophy attributed to nurses by Pender (1987).

A key to their mode of practice is that they were prepared to listen and to learn from those using their services, that they were self-effacing, putting those using their services before themselves (Chapter 3). Throughout the interviews they checked with me that they were giving me the 'right' responses: "How far do you want me to go on that one?"; "Is that the sort of thing you were asking?" Devault (1990:99) reports that the people she was interviewing asked her similar questions. For example, they asked "Is this what you really want?" She thought that the uncertainty that these questions revealed arose because their "talk didn't seem like an interview" (Devault 1990:99). Perhaps this was the case with the Plunket nurses whom I interviewed. They knew that my background was similar to theirs. It seemed that we talked the same language and I encouraged them to talk at length about what was important to **them**.

Questions about 'getting it right' can also be interpreted as signifying a desire to give socially acceptable responses. That these twelve nurses were prepared to take the risk of participating in this research (Chapter 2) suggests that they were not confined by a need to conform. Their responses also speak of people who are refusing to be oppressed by social pressures to conform. Each has spoken of stepping outside of the boundaries laid down by the Plunket Society in order to be more effective in her practice. Furthermore, it is important to preserve and understand the reality of the interview account and not to undermine it as conforming to the 'socially acceptable' (Chapter 2).

The mode of this research was directly comparable to the practice that these nurses were describing. That is, the desired nature of the relationship between the researcher and the other participants was that of I-Thou, and integrity is a dominant characteristic of such a relationship. It is very difficult not to be honest when participating in such a relationship. Additionally, the evidence from these interviews speaks strongly for a nursing practice geared to the needs of those using it. Such a practice requires a form of interaction that establishes as accurately as possible what those needs are from the perspectives of the people experiencing them. In order to establish these perspectives, questions like, "Have I got it right?" are essential. That the nurses asked these questions during the interviews suggests that such inquiries are habitual, a part of their professional repertoire.

The consistency of response across the interviews speaks for the integrity of participants. They worked first and foremost for those using their services, finding their rewards in seeing people—parents and babies—becoming more confident and more

self-sufficient as a result of their work. Their identical goals and rewards suggest a practice based on the previously mentioned principles which match those outlined by Freire (1972:62-65). As practitioners they were open to learning from all quarters and as they strove to improve their skills and knowledge in order to become more effective in meeting their goals, their own intrinsic progress contributed to the satisfaction that they got from their work. There was a close parallel between what was happening in their own lives and what they worked for in the lives of those using their nursing services. Their view of 'career' as 'a pathway through life' summed up this progress, which is best described as a progression towards personal integration and increasing wisdom.

The learning—understanding, tolerance, appreciation of cultural difference—valued by participants in this study is crucial to the pathway through life that they were following. As they pointed out, this kind of learning comes more readily from outside rather than inside the classroom. This too is similar to Freire's (1972:45-46) argument when he compares "banking" with "libertarian" education:

> Education is suffering from narration sickness...His (the teacher's) task is to 'fill" the students with the contents of his narration...it turns them (students) into 'containers,' into receptacles to be 'filled' by the teacher...Education thus becomes an act of depositing, in which the students are the depositories and the teacher the depositor...This is the 'banking' concept of education...
> (However,)knowledge emerges only through invention and re-invention, through restless, impatient, continuing, hopeful inquiry men pursue in the world, with the world, and with each other.
> ...The **raison d'etre** of libertarian education...lies in its drive towards reconciliation. Education must begin with the solution of the teacher-student contradiction, by reconciling the poles of the contradiction so that both are simultaneously teachers **and** students.

From their accounts, the nurses I have interviewed prefer what Freire calls "libertarian education" as teachers and as students. Freire (1972:53) continues:

> The teacher is no longer merely the-one-who-teaches, but one who is himself taught in dialogue with the students, who in their turn while being taught also teach. They become jointly responsible for a process in which all grow.

Here Freire could be writing about these Plunket nurses who were open to learning from everyone. Also his words "jointly responsible" resonate with the nurses' recurring worry about creating dependency. Libertarian education, as outlined by Freire, parallels that of Buber's (1985:132) description of I-Thou relationship between teacher and student. Nurses' responses in this study suggest that as nurses and teachers they work towards establishing I-Thou relationships.

Schaef (1987:29-32) refers to the work of Wegscheider-Cruse (1984) when she defines 'co-dependency' as: "An addiction to another person or persons and their problems, or to a relationship and its problems." She repeats Wegscheider-Cruse's claims that "co-dependents make up about 96 percent of the [U.S.] population," and

that 83 percent of nurses are co-dependents. I would suggest that the people taking part in this study, by their continuing concern about dependency, have shown that they are aware of the dangers of co-dependency, and that their awareness can be seen in Freire's terms as critical reflection. The outcome is a practice designed to avoid encouraging or enforcing a relationship of dependency by either service user or provider. It is, as I have mentioned, based on principles similar to those described by Freire. It also follows a process outlined by Freire (1972:61), who argues:

> Dialogue is the encounter between men, mediated by the world, in order to name the world. Hence, dialogue cannot occur between those who want to name the world and those who do not want this naming...If it is in speaking their word that men, by naming the world, transform it, dialogue imposes itself as the way by which men achieve significance as men.

The ultimate goal of the practice recorded in this thesis is to support people to achieve significance as people. In order to do this, participants base their practice on love, humility and faith in the Other—all elements perceived by Freire as necessary for the existence and maintenance of dialogue (Freire 1972:62-64):

> Dialogue cannot exist...in the absence of a profound love for the world and for men.
>
> ...dialogue cannot exist without humility ...How can I enter into dialogue if I consider myself a member of the in-group of 'pure' men, the owners of truth and knowledge, for whom all non-members are 'these people' or 'the great unwashed'?
>
> Dialogue further requires an intense faith in man, faith in his power to make and remake, to create and re-create, faith in his vocation to be more fully human...

That each person is the best expert on herself or himself was an underlying assumption within the mode of practice described. That parents were responsible for and capable of taking care of themselves and their children was a recurring theme.

The nurses' descriptions of their work support Freire's (1972:64) argument that love, humility and faith "produce a climate of mutual trust, which leads the people involved into ever closer partnership in the naming of the world." But according to Freire, hope is yet another necessary condition for the existence of dialogue. He (1972:64) describes hope in terms of reaching out, whereas:

> Hopelessness is a form of silence, of denying the world and fleeing from it...As the encounter of men seeking to be more fully human, dialogue cannot be carried on in a climate of hopelessness. If the participants expect nothing to come of their efforts, their encounter will be empty and sterile, bureaucratic and tedious.

Although no-one mentioned hope, it was implicit throughout the interviews in the insistence on the value of Plunket and the overwhelming emphasis on those using Plunket services. The fact that these particular nurses agreed to participate in this study

also speaks of hope; of people reaching out and taking risks. I have reported (Chapter 2) on the climate within nursing and The Royal New Zealand Plunket Society, as well as on the expressed reservations about participating in this study. It seems that it took a person with a particular amount of gumption and a particular amount of hope to agree to take part.

The final principle mentioned by Freire as a necessary condition for dialogue is critical thinking. Of critical thinking he (Freire 1972:65) writes:

> ...thinking which discerns an indivisible solidarity between the world and men admitting of no dichotomy between them—thinking which perceives reality as process and transformation, rather than as a static entity—thinking which does not separate itself from action, but constantly immerses itself in temporality without fear of the risks involved...For the critic, the important thing is the continuing transformation of reality, for the sake of the continuing humanisation of men.

Of all the principles outlined by Freire, this was the one on which participants showed some variation. All revealed themselves as engaging in critical thinking about dependency in relationship, cultural differences, and variation in need requiring a variation in response. But there was a continuum of awareness about themselves as community nurses. All were running groups of one kind or another, but while many saw themselves as family nurses, a minority saw their work as health development in the wider community. However, all perceived "reality as process and transformation," and through their participation in this study they revealed themselves as willing to take action, perhaps despite fear of the risks involved.

These nurses were no longer isolated, no longer the Cinderellas of the nursing profession. Perhaps it was their awareness of a wide diversity of needs, together with their strong focus on a better life for service users, that lead them to search for more knowledge and more skills and to work more closely with others. Their changing practice brought them into increasingly frequent contact with other health workers. While this helped to introduce more people to the reality of their work, it seemed that there were others who still did not understand the nature of Plunket nursing. Most importantly, those who made policy decisions about Plunket nursing did not seem to be able to 'see' from a Plunket nurse's perspective.

Schaef (1981:152-159) in her framework called 'Levels of Truth,' describes a pathway towards enlightenment. This framework closely approximates the pathway described in this study. While the traveller can see the path behind, the path ahead is hidden from view. The journey is difficult and progress involves dialogue as described by Freire. The experiential learning valued by these nurses involves the same kind of dialogue, and the approach leads to learning about people and the human condition. That the nurses recognise this is evident from their grave concern about both the

reduction in consultations, including home visits, and their increasing workloads. Dialogue requires contact and time.

As I write I remember the reactions of people who accompanied me, for one reason or another, when I was working as a public health nurse. In particular, their reactions to entering the homes of people managing to live on very low incomes. There was the medical officer of health who said that he hadn't seen anything like it since he worked in a 'London slum'; the student nurse who was surprised by the sparseness of the interior of a house and the accompanying robust humour of its occupants; the wonder of a polytechnic tutor at the support networks of people living on minimal incomes; the appreciation of a young intern, specialising in family practice, of the concern of parents for their children. At that time, student nurses from both hospital and polytechnic programmes accompanied me. I found it much easier to take students from the latter into the homes of people living on very low incomes. When I taught within the polytechnic programme concerned I found that the first year curriculum included a high proportion of experiential learning, and that students were encouraged to reflect on attitudes and values associated with class, race, ethnicity and gender distinctions. On the whole, therefore, these students showed more awareness and sensitivity than the students from the hospital programme.

We tend to live and work within a particular grouping or groupings and it is difficult to see how people outside of these groupings live. Someone working as a Plunket nurse, visiting many people at home, has inside knowledge of many different lifestyles. This knowledge, providing the nurse practises according to the principles described above, brings appreciation and understanding of difference. The nursing practice described in this study allows for a positive self-fulfilling prophecy. The nurses' faith and hope in the people using their services, gives families space to move in the direction of health. Furthermore, their approach towards developing mutual trust increases the likelihood that if there are serious abuses occurring within a family that someone in the family will request help. And a home visit **is** a critical part of this process. As Plunket policy recognised, where needs are most extreme more visits are required, but from the nurses' accounts the overall retrenchment was severely hampering them in their work.

There are two final points worth noting. First, there is support in this study for Norton's (1990:35) conclusion that there were "issues of power inherent in the organisational structure [of the Plunket Society] and the consequential interpersonal relationships between the groups involved and questions concerning professional issues for the nurses." This study also revealed a need for more support in the form of supervision for Plunket nurses, as well as a need for more time for reflection on practice, planning and the cooperative organisation of work.

Second, unlike Salmond (1975), Briggs and Allan (1983), Ford et al (1990) and Norton (1990), I have found a lack of support for Hart's Inverse Care Law (1971). Admittedly, this research was not designed to investigate accessibility from a service user's perspective, but on the other hand, the nurses' own accounts demonstrated a desire on their part to deliver a service that reaches everyone. This was illustrated by both their stated goals and their reports of efforts to be accessible (for example: leaving notes as reminders of group sessions, visiting at home when it was difficult for the people concerned to keep clinic appointments, running a variety of groups in a variety of ways and in a variety of locations). As Robyn said (see Chapter 9): "We have made a lot of changes. It [Plunket nursing] was always classed as a middle to upper class organisation, but it's not any more."

Critique of the Study

A study such as this can be criticised on the grounds of predictability and reliability. In terms of generalisation and prediction, as mentioned in Chapter 2, I agree with Smith (1987:157). I would maintain that any nurse practicing from the philosophy outlined in this study would be extremely effective, but might also attract the ire of other health workers who adhere to a more authoritarian mode (see Chapter 8).

Also as mentioned in Chapter 2, I do not regard lack of reliability as a problem. In fact, I assume that the social world is in a state of constant change. This study has recorded a particular nursing practice which conforms to principles inherent in the work of both Buber (1958) and Freire (1972). It is also consistent with the movement within nursing towards a caring philosophy (Bevis and Watson 1989). It stands as a reflection of this kind of philosophy.

This research could be seen as limited in its scope in two ways. In one sense it is limited because it is too narrow: only Plunket nurses were studied and a self-selected group at that. Therefore it cannot stand as representative of all Plunket nurses, let alone all people involved with The Royal New Zealand Plunket Society. Second, it is very broad, covering a wide range of topics. In each of these areas it is only a pilot study. However, overall the study does what I intended it to do. It begins to establish a voice that is not well-represented in the literature and it offers support for the view that some Plunket nurses are working in affirmative ways with the families using their services.

My concern that familiarity with the experience of community nursing would lead me to shape the results to fit my own views was alleviated by the nurses' recognition of the picture reflected back to them in the draft copies of the thesis. Most requests for change concerned identification. Those that related to content, asked for sharpening and

emphasis of what had been said. The general reaction was one of recognition, plus delight that each was not alone but a member of a group with a shared vision. As it happens, therefore, the outcome does fit my own views, but these coincide with the views of those who participated.

As the study progressed, and I accumulated over three hundred and thirty pages of single-spaced transcript from interviews, I regretted the length, scope and repetitiveness of the questionnaire. Perhaps the same study could have been achieved with in-depth interviews with one person to produce a 'topical' life history, but in the end I have quoted liberally from everyone. To keep the study to a manageable size, however, it was necessary to be selective to avoid unnecessary repetition, and amongst the twelve people participating someone always put a particular point better than anyone else. Although the repetitiveness of the raw data increased the time required for analysis, it nevertheless served as a check on internal validity with responses from each participant consistent throughout the interviews.

The two most remarkable aspects of this study for me, were first the consistency and freedom of response and second that I interviewed twelve nurses with viewpoints so similar to each other that they could be seen as a single standpoint. It seems that my similarity to those whom I was interviewing contributed to the high degree of rapport that occurred in each interview. Finch (1984:79) describes a similar experience when she, as a woman married to a clergyman, interviewed other women who were also married to clergymen.

The content, design and method of this study share two major themes—relationship and vision. The quality of relationship between myself and those who participated was a central concern (Chapter 2), as was a lack of vision (or voice) in the academic literature. I wanted to allow Plunket nurses a voice, to establish a fresh standpoint, and to involve dialogue in a research process which would be informative and empowering. The research process mimics the nursing practice described in the study.

Throughout the study, however, I have felt constrained by the requirement that I chop up each person's response in order to identify themes and patterns, and to provide salient illustrative quotes. Reflecting on this process, Freire's (1972:45) description of "banking education" seems to be particularly appropriate. He writes of reality treated as if it were:

> ...motionless, static, compartmentalised and predictable...contents which are detached from reality, disconnected from the totality that engendered (it) and (that) could give it significance. Words were emptied of their concreteness and become a hollow, alienated and alienating verbosity.

I found that in the course of my interviews with the nurses the same themes surfaced again and again in different contexts and connected with each other in different ways. I have broken these links, but I have also tried to indicate that they exist by leaving in some longish quotes, and by trying to pull them back together in frequent summaries. The nurses themselves, in their recognition of the picture I reflected back to them, speak for its veracity. In retrospect therefore, should I repeat this study, I would follow the same process.

SUGGESTIONS FOR FURTHER RESEARCH

As an initial investigation, this thesis raises a number of further possibilities for research related to the major themes within the long interview. For example, further investigation of both the literature (across disciplines) and of diverse perspectives towards work, motivation and career (Chapter 3) would facilitate deeper understanding of these perspectives and their impact. More specific to Plunket, from the standpoint of the nurses in this study there are problems related to the understanding of different roles within the Plunket Society (Chapter 8). A larger study, investigating simultaneously the standpoint of Plunket volunteers, administrators and decision makers, as well as nurses, offers the possibility of: increasing the shared knowledge of each others roles; facilitating open communication; removing constraints felt by Plunket workers as a result of not understanding each other; and allowing the Plunket Society to operate more effectively and efficiently. Questions could focus on goals, constraints, rewards, the understanding of roles and who makes the decisions?

There is, in the literature across disciplines, discussion of two kinds of learning. One, labelled by Freire (1972:45) as "banking education," occurs when new facts are assimilated into existing mental schema. The second is revolutionary, occurring when new facts require reforming of existing schema (see for example: Harrison 1991; Kuhn 1970; Watzlawick et al 1979:10). Often it is the latter which is required in order to 'see through the eyes of another,' and it seems that experiential learning is the most effective way to achieve this. From the nurses' accounts, their experiential learning has been of major value to them in their work (Chapter 4). Therefore, on a practical level, a study which records and collates experiential learning packages used in nursing, social work and counselling could be of benefit as a resource for those teaching and studying in these courses.

Relationship has proved to be a key theme in this thesis, and relationship between Plunket nurse and service user is central to Plunket nursing. In Chapter 1, I referred to a number of studies based on Hart's Inverse Care Law. Fergusson, Horwood, Beautrais

and Shannon (1981:58-59) in considering policy options in order to improve access to child health services, offer three alternatives: an increase in funding, health education to change attitudes towards the service, and "radical change in both structure and underlying philosophy of the New Zealand health system." Since 1981, The Royal New Zealand Plunket Society and the New Zealand health system have undergone radical structural change. Furthermore, there has been a radical change in underlying philosophy at government level, leading to reduced state funding to voluntary organisations. There are, from the nurses' accounts, indications that a public education campaign would be to the advantage of potential users of Plunket services. Thus, a study combining qualitative and quantitative techniques, with a focus on Hart's Inverse Care Law (1971), in a small geographic urban area in which there is increased public education and funding, would help to establish just how much these changes could contribute to overall health status. There are already a number of studies (Chapter 1) which could serve as a base-line for such a study, at least two published as recently as 1990 (Norton 1990; Ford et al 1990).

Finally, an implication of the Broverman et al (1970) study, cited in Chapter 3, is that characteristics like nurturance, affiliation and cooperation are not valued. This echoes with the nurses' emphasis on the importance of caring, while they simultaneously express disappointment in the lack of appreciation they receive for their work (Chapter 3). An emphasis on the value of traits such as connectedness can be interpreted as co-dependency (see Schaef 1987:30). However, the Plunket nurses in this study, in addition to their focus on caring, emphasised a need to see others become healthier (Chapter 3), and throughout the interviews they demonstrated an awareness of the dangers of promoting dependency. Further research is required to answer concerns about health professionals fostering dependency as a result of their own potential co-dependency needs. Such a study could help to clarify how and why some health professionals encourage dependency while others do not. This kind of knowledge could serve as a guideline for those who are responsible for preparing people to practice as health providers, with the end result that health service providers generally become more effective in their practice.

POSTSCRIPT

I began this study with the idea of 'cultural mosaic' as a metaphor for societal groups. As a result of listening to twelve Plunket nurses I now have a view of society which can be symbolised best by a three-dimensional mosaic, with tesserae—also three-dimensional — separated slightly from each other but connected by gossamer threads in multiple and complex ways. As one tessera moves the whole mosaic shifts. This movement is not only complex but continual. Thus the scene revealed is in a state of continual flux and the view of it at any one time shifts according to the position and former learning of the viewer.

APPENDIX 1: RESEARCH CONTRACT

I, ... agree to be interviewed for the research project "The Standpoint Of Plunket Nurses," to be conducted by Joan Lambert as part of an M. Phil. in Social Policy at Massey University. This means that:

1. I agree to take part in a 2 hour interview, with a brief follow-up interview about two weeks later with the researcher, at a time that we have agreed to.

2. I am free to withdraw from the research at any time without any repercussions. If I decide to withdraw, the tape and transcript will be returned to me.

3. Confidentiality of information given in the interview will be protected throughout by the following measures:

   i) The interview tape(s) will be listened to only by Joan Lambert.

   ii) Parts of tapes will be transcribed, but the transcripts will be seen only by Joan Lambert.

   iii) Once the interviews have been transcribed, all names will be changed.

   iv) Material from the transcripts may be used in the final thesis, but only in such a way that the person who was being interviewed cannot be identified. The thesis will be available to me before it is bound, so that I can ensure that I cannot be identified within it. Any special identifying features will be removed from the thesis.

   v) The tapes and transcripts of confidential interviews will be erased within three months of the completion of the thesis.

4. I am aware that the interview will cover such things as my experience as a Plunket nurse and my views of the place of Plunket within the wider social context.

Signed .....

(Interviewee)

.....

(Researcher)

Date .....

APPENDIX 2: INTERVIEW SCHEDULE

Plunket and the Health System

There are no right or wrong answers to the following questions. This is an opportunity for you to reflect on your work and its context. I want to begin with your perception of the health system and Plunket's relationship to it:

- When you think of the health system, what sort of things do you think of?
  What do you see as making up the health system?
  What are your thoughts about health practices such as homoeopathy; iridology; health practices within other cultures?
- How do you see and how do you describe the importance of the Plunket nursing service?
- Do you believe that your perception is shared by other Plunket nurses?
  - by users of the Plunket service?
  - by other health workers [paid and unpaid]?
  - by policy makers?

Education

As a nurse and as a Plunket nurse you have received formal education and training.

- Thinking back on this education and training what has been most helpful for you?
- Is there anything that you would like to see added to this education and training?
- To what extent has your work experience contributed to your work effectiveness?
- Is there anything in particular in your own personal background that helps you do your work?

Goals

Initially you talked about how you see the Plunket nursing service fitting in with the health system, given these views:

- What are your personal goals as a Plunket nurse?
- What are your goals in relation to other people (paid and unpaid) working in the health system?
- What are your main motivations as a Plunket nurse?
- What are your thoughts on the career structure within Plunket?
- Do you see yourself as having a career? If so, how do you view your career?

Relationships

I would now like to explore with you your idea of the ideal relationship between a Plunket nurse and users of the Plunket service, and the ideal relationship between a Plunket nurse and other health workers.

- In your opinion what would be the ideal relationship between a Plunket nurse and a parent? (adviser? controller? resource?)
- What would be the ideal relationship between:
  - a Plunket nurse and another health professional?
  - a Plunket nurse and a volunteer?

Support and Constraints

As a public health nurse I found that some things helped me to do my work, while other things hindered me. In this section I would like to explore if this is the case for you.

- Do you find Plunket nursing personally rewarding?
  - if so, in what ways?
  - if not so, what is not rewarding about it?
- What things about your job are a source of energy or strength, giving you a sense of your dignity as a Plunket nurse; a sense of your worth?
- Is there anything that prevents you from working in the ways you would like?
  - external—within Plunket organisation?
  - external—outside of Plunket organisation?
  - internal—self limitations?
- Are there personal costs in being a Plunket nurse?
  (fatigue? frustration? emotionally draining? insufficient time to relax? insufficient time with family?)

Change

I want to get onto the topic of change in terms of health care and in terms of Plunket within the health care system. You might have answered some of the following questions already, but possibly you might also want to add something here.
We are all experiencing rapid change in New Zealand because of changing government policies:

- How do you see these changes affecting the Plunket service?

Are there any trends that you see as positive for yourself as a Plunket nurse and for the women and children with whom you work?
Are there any trends that you see as unhelpful?
- for users of Plunket services? - for nurses?

- Have you observed any positive changes in Plunket Society policy since you have been working as a Plunket nurse? if so, what do you see as the sources of this change?
- Are there any changes within the Plunket organisation that could be made that would help you to improve the service that you give?
- Can you see any ways that you could contribute to these changes?
- Have you brought about change at any time? If so, how have you done this? How successful do you think you were?
- If you haven't been involved, but became involved now, how successful do you think you would be?

Is there anything that we haven't covered that you see as important and would like to talk about?

APPENDIX 3: BIOGRAPHICAL DATA

name .....

what is your date of birth? .....
day month year

where were you born? .....
country

ethnicity
- Pakeha (European)
- Maori (state tribal affiliation)
- Pacific Islander
- other (describe)

household
- person living alone
- parent with child(ren) - (please include number and ages)
- couple
- couple with children- (number and ages)
- extended family
- group (friends/flatmates)
- other (please describe)
- if not living alone are you living with a person or person's who require care?

tertiary qualification(s) (please list and indicate where obtained)

for what period of time have you worked for The Royal New Zealand Plunket Society? (please indicate broken years of service)

former paid occupation

Have you been in paid occupation other than nursing?
If "Yes," please describe any former occupation(s) undertaken for twelve months or more.

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