

How can nurses address generalist/specialist/nursing requirements of the  
urban/rural population of Southland?

by

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**Abstract:**

This study, which is undertaken in the Southland area, explores the effect of the increasing specialisation of nursing services in what is a rural/urban environment. It is indicated in the literature that systemic changes in health, such as the health reforms, and the increase in the use of technology have meant that nurses are required to function in disease oriented roles rather than according to their more traditional generalist roots. A significant event, which also affected nursing scope of practice, was the transfer of nurse education to the tertiary education institutions environment from the hospitals in the mid 1970s. The traditional nursing hierarchy and its nurse leadership role disappeared and the adoption of specialist nurse titles increased, and identified with a disease or disorder, for example 'diabetes' nurse. The increase in specialist categories for patients contributed to the nurse shortage by reducing the available numbers of nurses in the generalist nursing pool. The nurses in this rural/urban environment require generalist nurse skills to deliver their nursing services because of the geographical vastness of the area being a barrier to specialist nurses. Workforce planning for nurses in the rural /urban then must focus on how to reshape the nursing scope of practice to utilise the existing resources. This study explores how key areas of health services could be enhanced by reclaiming the nurse role in its holistic approach, in mental health, public health, geriatric services and psychiatric services.

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## Introduction

*“Use my words and you will begin to think my thoughts” (Mao Tse Tung).*

(Baker, M. 2001).

This inquiry is positioned primarily from the mid 1960s to the present which is the extent of my continual experience as a practising Registered Nurse in both clinical and management positions in Southland, New Zealand. My approach to this research paper then is influenced from those two perspectives. Overseas travel has enabled me to practise nursing in the international setting as well and this has added another dimension. This study was inspired by my observation that nurse autonomy appears to have lessened since the changes in its education structure from the hospitals to the tertiary institutions, and the influences of the health reforms have further eroded this autonomy. Nurses, particularly in the institutions, are involved more in the co- ordination and delivery of care that is prescribed by other health professionals and to meet the needs of the health reforms, rather than holistic nursing care. The complex environment of health is created by technology not only related to direct patient care, but also to information technology and the use of sophisticated processes for the delivery of medications and treatments that may take precedence over the patient’s personal human needs. The emphasis on ‘throughput’ in the hospitals does not acknowledge the increasing numbers of people diagnosed with medical ailments (that are really ‘social ills’), which continue to overload the health system. This ‘outcome’ terminology makes its appearance in the nurse care plans, which used to be an historical account of patient/client progress before the tertiary education of nurses adopted an ‘outcome’ approach to nurse care plans.

The continuous shortage of specialist doctors such as psychiatrists and geriatricians here in Southland and the response to this has not been the utilising of the expert knowledge of nurses in a holistic generalist sense but rather the adoption of specialist nurses as a singular response initiated by the medical profession. These roles have evolved subjectively in many instances, such as ostomy and diabetes specialists, to act in an assistant role to the medical consultant. Blurring of roles between specialist and generalist nurses as well as a lack of role description and accountabilities, has added to the difficulties of delivering a patient- centred service. The rationale for this study then,

has been to examine how nurses can address the generalist/specialist health requirements of a rural/urban population. Consideration in this study is given to the effect of 25 years of tertiary education and the health reforms to the nursing profession. In the early years of my nursing career as a student nurse (in the mid 1960s) there was an informal acceptance of the need to consolidate practice following registration. The title of 'staff nurse' was gained at registration followed by 'staff sister' a year later. Accumulatively then, there was a guarantee that when the 'staff sister' title was achieved the nurse had at least four years clinical nursing experience. This included the three years student nurse training within the hospital. Nursing practice itself was autonomous as I observed through the charge nurses of the hospitals. They planned and delivered nursing care using the input from the Medical profession's diagnosis of a patient as a baseline. The consultants' preferences for the treatment of their patients was woven into nursing care as was the charge nurse's individual preference for care of her/his patients, woven into the care that the students provided. There was the opportunity for the student nurse to observe the practice of the senior nurse mentors and apply it to practice.

My recollection then, was that following registration a preference for surgical, medical, district or public health nursing, were all options for the graduate nurse to pursue. Consolidation of basic nursing skills was essential to the process of later adding specialty skills, which could be learned in the rural/urban environment of Southland. There was not always immediate mentoring available to nurses practising in geographically remote areas and therefore the generalist skills were necessary to care for the broad patient base. There was a certainty though, that a level of experience in generalist nursing had been achieved which was transferable to these various settings and in the rural/urban environment of Southland this was an effective way to deliver health services to the community. In the more remote areas for example in Te Anau or Manapouri, a community would be served by a nurse with generalist skills and if a particular specialist component such as public health input for schools was required then appropriate specialist education would be provided. Close liaison between the hospital and district nurses ensured for the most part an effective discharge structure and this was essential in a rural/urban environment. I would stress that the nursing role was definitive and quite autonomous within a structure that was built on clear role definition within the nursing profession and those boundaries known to the medical profession. During the 1960s and 1970s the increase of technology within medical practice was initially



confined to the critical care units and to the use of rudimentary heart monitors and respirators. In the following years (1980s onwards) advances in technology escalated and specialist knowledge was needed to maintain the operation of the equipment that had become highly sophisticated. Nurses were directed towards becoming 'specialists' to assist doctors in their sphere of practice, which was becoming more and more specific to body parts. Nurses informally became 'specialists' and adopted the names of diseases or disorders to describe their function. There was a change observable in nursing in the mid 1970s, which came about with the transfer of nurse education to the tertiary education institutes (Carpenter, 1971). The nursing autonomy, which was previously protected within the hierarchal system of nurse training within the hospital environment, was now unprotected by the nursing profession.

The health reforms in New Zealand, which started in the late 1980s, included a change in terminology within the health sector, which was born in the business environment, and I refer here to the relevance of the quote that begins this introduction. Nouns became verbs through constant usage and then personified. For example, a patient became a consumer, which implies a 'user'. This term is used when describing the psychiatric patients in particular who are referred to as 'users of mental health services'. The dictionary meaning of 'consume' is, "Make away with, use up, eat or drink up:" (Pocket Oxford Dictionary 1975 p.173). This bewildering array of new terminology, which entered the health environment, for example, 'contracted' services, 'interventions' and 'outcomes' was also constantly changing and often meanings were unclear. Alongside this the position of 'charge nurse' was removed at the hospital where I was employed. Instead, a generic management concept was introduced to ward nursing and it was reiterated that nurses' clinical skills and knowledge were not required in the new management structure. They were there to 'manage' the ward. When this concept failed, the positions of 'co-ordinators' were introduced to act as clinical 'resources' but there was no indication of skill or experience level within these positions and there was little knowledge of the vital link between hospital and community nursing services. Referrals for follow-up community care for the patients on discharge from hospital were not actioned due to the loss of knowledge of the link between the hospital and community. This was a serious breakdown in the provision of health services to the rural/urban environment, and the people who had a right to do so, did not use available nursing services. I began my management career in health in the mid 1990s and observed that

nurse practice was influenced by the requirements of a business environment. Consequential legislation required care 'outcomes' in the delivery of care by unskilled personnel. The care of patients that had once been delivered by registered nurses was now being delivered by care givers and their training, supervision and competency became the responsibility of the providers without the funding to sustain this.

### **Why this study?**

I first became aware of the specialist nurse concept and its introduction in the mid 1980s. I decided to undertake this study because the specialist nurses were my responsibility as a nurse supervisor of District Nursing. It was difficult to manage the situation where experienced District nurses now had to refer their patients to specialist nurses despite previously caring for them holistically. The specialist nurses included; two cardiac nurses, one in the hospital and one based in the community (the latter being the one whom I was responsible for), one psychiatric nurse, one oncology nurse who I was responsible for, and one other whom I was not responsible for who gave medication in a clinic setting. There were also two diabetic educators, both based in the hospital, and one with community responsibilities, neither of whose function was clear to anyone. I was responsible for the 'community' nurse. The effect on the generalist nurse practice was not considered for a rural/urban setting but the contracts with the health funding bodies, for example the Ministry of Health required the input from specialist nurses to fulfil contractual obligations for example a specialist 'continence' nurse. The transfer of nurse education to the tertiary institutes during the 1970s (Carpenter, 1971) and the health reforms of the 1980s and 1990 were significant in shaping nurse practice as well. The hierarchal system of nursing was seen by nurses to be no longer relevant with the new education programme for nursing. The theory promoted in the 1980s at the hospital where I worked was that nurses were practitioners in their own right and that supervision of nurse practice was no longer required since hospital programme student nurses no longer existed. The introduction of the health reforms in the mid 1980s ensured that the now weakened hierarchal system within nursing was finally removed. At the Southland Hospital there was a process undertaken where the older nurses who had served the public for many years were now surplus to the new order, and were removed in a manner that did not reflect well. I know that the nursing profession did enjoy autonomy when I

practised during the hospital training era. My observation presently is that nurse practice is controlled by the business philosophy, by specialisation, and by other health professionals, all of which is supported by legislation. For example, nurses who form the largest group of health care professionals are the only group within a Public Hospital who are unable to contract with the funding bodies for services to the public. This, despite the fact that nurses provide the most care as a group. This has removed what autonomy nurses did have once to the present situation where the nurses role is principally as 'agents' for others. The nurse tradition of holistic care cannot be delivered under these circumstances so new therapists are entering the areas left vacant by nurses who are pursuing specialisation.

It is my observation over my years of practice, that the terminology of the business sector while legitimate in a business environment has changed the philosophy of nursing. New technology and procedures to increase 'throughput' are publicised and new graduates prefer to work in areas of nursing that are not related to long- term care, for example people with enduring chronic illness such as multiple sclerosis, paralysis resulting from cerebral vascular accidents, and reduced mobility from heart disease. Alongside these observations is the experience I have of seeing that chronic illnesses require a holistic approach and that the resource capability of the specialist nurses seems confined to the acute care model assisted by the specialist nurses being based at the hospital in a curative environment. This, despite the fact that Southland has an ageing population with recruitment and retention of registered nurses posing an ongoing problem. There is a resurgence of interest in the touch technique of massage and these therapists now deliver their services in palliative care settings and in hospitals. I well remember when the massage of patient's limbs was stopped as it caused 'tissue breakdown'. As well, the increased demands of technology in the health environment require that nurses in the acute areas have a high level of skill related to maintenance of equipment, and they cannot always attend to both equipment and patient needs within the time available.

In a rural/urban area such as Southland it is important that where nurse education is undertaken in partnership with the tertiary education institute, a plan is formulated to consolidate practice in the setting of chronic illness and disease management. To address these concerns, nurses should reconsider the generalist approach to the nursing art. It is

not possible to be an autonomous profession while the priority of care is carrying out the instructions of other health professionals. I position this research in the rural/urban setting of Southland as it is an environment that I am knowledgeable about and where the development of specialisation is a threat to nursing in the rural/urban environment. The New Zealand nursing tradition has been built on the practice of holistic nursing and this has been its strength. I became more aware over the years that nurses themselves seemed to have less autonomy over their practice despite this being an objective of the move from hospital based training to tertiary education institutes. The overall aim of this study is to have the reader reflect on how nurses can address generalist/specialist nurse requirements of the rural/urban population of Southland.

### **The Literature Search Strategy:**

I started my literature search amongst the nurse writers on the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database using the key words 'nursing' and 'specialist'. Journal articles that related the experiences of nurses perceiving difficulties in specialist versus generalist nursing are evident, for example there was difficulty in identifying what amount of care is carried out by an individual practitioner when health care is based on a team concept (Read, 1994). Another author goes on to say that the generalist nurse is an endangered species because the wards are invaded by an increasing army of nurses who are specialists (Shepherd, 2001). International authors Bushnell, Cashman, and Fulmer (2001) state that systemic changes have required nurses to function in illness oriented roles than in their more traditional generalist roots. Perkins (1997) comments that the division of labour and its required management has a significant impact on the fundamental structures of 20<sup>th</sup> century medicine and that the specialisation of nurse practice cannot be isolated from the evolution of health care delivery methods in institutions. These two are interlinked as technology relies on specialisation of medical practice, which in turn relies on institutions to purchase the technology. Nurses then must adapt their practice to assist in the use of the technology specific to body parts, which are treated separately from the whole body. Management theories from Australian authors, Robbins and Barnwell (1994) who state that the Industrial Revolution of the eighteenth century was a milestone with its effect on

organisational theory with its division of labour, provide another link with the specialisation of nursing practice.

My search of the literature did not produce a synthesis from any New Zealand nurse of the effects of the health reforms on nursing's scope of practice and the increase in specialisation of nursing practice, even though it is a period of 15 years since the beginnings of the health reforms. There were however other writers such as Gauld (2001) a senior lecturer in health policy at the University of Otago. He provided a comprehensive background to the health reforms that I could align with the writings of two New Zealand nurses and their research on nursing history (Burgess, 1984; Cullens, 2001). Beekman and Patterson (2002) however did write about the health reforms as affecting nurse practice and the potential of the nurse practitioner role. International nurse writers such as Emden (1991), Cody (1996), and Sandelowski, (1997) share a commonality in attempting to define a nursing scope of practice. It is significant that there is still debate and uncertainty over nurse scope of practice after many years. This may be attributed to the variety of settings in which nurses' practice and of course this has increased with specialisation.

## **Social Policy**

I began to access educational literary sources from the database at Victoria University of Wellington, which led me to reading social policy from Wilding (1982) Hessler and Twaddle (1977), Davis (1981), and Richards (1981). These authors discuss the control of the health professionals themselves over the delivery of health care. Other factors were significant in the nursing trend towards specialisation. Gauld (2001) comments on the health reforms of the early 1980s to the present and the reviews of public hospitals by accountancy consultants. As the trend towards specialisation increases then consequentially so do new conditions and diseases. Davis (1981) states that established disciplines like medicine have public acceptance of their technical terms, one reason being that they are esoteric to the general populace. Emden (1991), refers to eclecticism in the philosophical underpinnings of nursing. Given that little has been written about eclecticism and its effect on the delivery of nursing services in New Zealand I consider it is timely to consider the shifts that have occurred in generalist practice in New Zealand

and the impact this has on the health needs of rural/urban communities such as Southland.

## **Overview of Paper**

The New Zealand health reforms of the 1980s and 1990s with their subsequent effect on nursing services has largely been unreported despite there being a decade of constant change. Nurses practice in every health setting, their numbers form the largest group of health professionals and yet changes to their scope of practice has been reshaped from its holistic traditions to the requirements of a business philosophy.

The introduction of nurse education to tertiary institutes in the mid 1970s had further consequences to nursing scope of practice with an individualistic approach to the delivering of nursing services. This was aided by the removal of the traditional hierarchical structure of nursing in the early to mid 1980s here in Southland. The individualistic approach continued with the arrival of the specialist nurses into what had formerly been a generalist nursing environment suited to the delivery of nursing care in the rural/urban environment of Southland.

## **Section One**

In this section I provide a brief overview of the historical and legislative background material relating to generalist and specialist nurse development in New Zealand. Following on from this is an outline of the effect of how the tertiary education of nurses influenced the nursing scope of practice to a more individual approach to patient care. The shortage of nurses in the rural/urban environment is discussed.

## **Section Two**

The discussion in this section will be on the health reform influences at a local level. A view of the power of the professions and how health and social problems can be medicalised is discussed. Finally a glimpse at whether the health services may themselves be outside their scope of practice.

**Section Three:**

The future implications for rural /urban health needs in Southland are discussed. There is an overview of the Southland specialist nurse services related to psychiatry, cardiac, diabetic, geriatric and public health.

## **SECTION ONE Development of Generalist and Specialist nurse roles: Historical and Legislative background material**

### **Nurse Titles prior to 1970s**

The term 'Generalist Nurse' had its beginnings in New Zealand in 1901 on the 12<sup>th</sup> day of September when this country became the first to have separate legislation for the registration and regulation of nurses. All nurses on the General Nurse register received a medal. As nursing practice became more specialised, separate registers were established for maternity nurses (1925), nursing aides (1939), psychiatric nurses (1944), male nurses (1945), psychopedic nurses (1960), community nurses (1965), and comprehensive nurses (1977). Then in 1977, community nurses became enrolled nurses. (Nursing Regulation in New Zealand 1901-2001). In 1904 the Midwives Registration Act was passed.

In May 1907 attention to maternal and infant health was reflected in the introduction of the 'Plunket Nurse' following three-month training for general nurses and six months for registered midwives. The district nurse concept was introduced in 1901 (Burgess, 1984). In the late 1940s continued change in the community saw the introduction of the 'Division of Industrial Hygiene' in the Department of Health and this title changed to the 'Department of Occupational Health' in 1950. This industrial health nursing was later introduced into the public health nursing section of the Division of Industrial hygiene. This division of industrial hygiene was created in the Department of Health in 1947 (Burgess, 1984). Information from the literature that records the historical development of New Zealand nursing suggests a responsive process to the nursing needs of a young colonial country's population health requirements. Burgess (1984) states that people of good-will attempted to provide an organised health service and as a result a small hospital for Maori was established in 1842. Burgess also notes that the general hospitals which began to appear from 1840 onwards did not admit certain types of patients and these were maternity patients, psychiatric patients, and infectious disease patients. A reason is not given for this. However there was recognition that these 'conditions' did not require institutional care. Maternity nurses, midwives, and psychiatric nurses were later to be registered.



There were three programmes that led to registration as a nurse and these were each three years in length and strongly orientated to hospital nursing service. These were psychiatric, psychopaedic, and general nurse programmes. The psychopaedic training qualified these nurses for the care of the intellectually handicapped (now known as intellectual disability). The term of 'general' nurse was synonymous over the years with the nurses who had not had any particular specialist training outside of the apprentice style training that occurred in hospitals from 1901 until the 1970s. The psychopaedic and psychiatric training programmes were phased out in the 1970s and the curriculum of the tertiary education institutions included these components in the comprehensive nurse curriculum.

### **Shift in Nursing Titles from the 1970s**

Historically, the Nursing Council of New Zealand added nursing groups to the Nurses register but this did not occur with the specialist nurses who began to appear in the mid 1970s. Castledine (2001) says that the emergence of specialisation in nursing began in the early 1970s. The titles of nurse speciality practices were becoming more common, for example, ostomy nurses, dialysis nurses, cardiac nurses, diabetic nurses and others with titles that related to an individual disease process. This departure from usual practice can only be speculated on and it may be related to the individualism of the titles and the potential for numerous registrations. However, this process of adding nurses to the register usually was endorsed by a social mandate from the community groups who saw a need in a population group requiring a specific health service. For example, Plunket Nurses. These additions to the register had always been related to primary health care and not secondary health care, and an example of the difference is the Plunket Nurse vis a vis the ostomy nurse. There were political reasons for the adoption of the Plunket nurses particularly in the early 1900s as the maternal and infant mortality rate was alarming (Burgess, 1984). Sir Fredric Truby King was one of New Zealand's most well known doctors and he laid the foundation for this service with a vision for improving infant welfare as well as the mother's welfare, which eventually became the backbone of a fledgling health system (Andrews, 2001).

Titles have always played an important part in the organisation of society and it is no less important in the society of health care. In New Zealand the individual specialist nurses titles, describe the disorder or disease and influence the care that nurses provide. Previously, titles related to nurse groups such as 'Plunket' Nurses, Public Health Nurses, and Psychiatric Nurses to name some examples. In these groupings there was a generalist theme with a team concept. The individual specialist nurses titles, relate to an individualistic approach (since the 1970s when their practices had their beginnings). Nurse specialty practice was driven by doctors who were in turn being driven by a response to the rapid development of technology. Doctors needed to adopt the use of equipment that was sophisticated and less traumatic to patients. From my observation titles were conferred on the nurses who were working in the specialist areas, often alongside specialist medical areas. However, there was no proposal to the nursing bodies for these positions or recruitment process undertaken. Rather the specialist doctors requested that a nurse fill the role of assisting them in their work. A formal recruitment process ensures that there is a position description, that clinical standards exist, and criteria to ensure best practice, which safeguards the public. Educational qualifications can also be examined as well. The Carpenter Report (1971) identified concerns with the education of nurses. Over a considerable period of time the Division of Nursing, Department of Health, the Nurses and Midwives Board, and the New Zealand Registered Nurses' Association had all expressed dissatisfaction with the methods of the time in preparing nurses for practice via the apprenticeship approach (Carpenter, 1971).

The Nursing Council of New Zealand (NCNZ) replaced the previous Nursing statutory body with the introduction of the Nurses Act in 1971 (Burgess, 1984). The NCNZ approves courses, sets state exams, maintains registers, and provides annual practising certificates, sets standards and competencies and conducts disciplinary hearings. Its fundamental purpose is to protect the public ensuring that nurses are safe to practise (Nurse Practitioner, 2001). As referred to earlier there is no separate register for 'specialist' nurses. If the nursing body had monitored the development of the specialist nurses then medical models may have had less influence on their practice. This is because there would be a scope of practice that would be nursing orientated. There was a consciousness in the early years of New Zealand's development that the State must safeguard the social welfare of the country. The creation of a register of nurses was a natural follow on from that realisation (French, 2001). There was an attempt to undertake

a prevention of illness approach to health in the early days of New Zealand and this was to be the philosophy of the Social Security Act in 1938. McGuigan (1975) states that the new direction in health in the Social Security Act of 1938 was to be a focus on the prevention of illness as opposed to cure. By 1936 however the medical profession had hardened its resolve not to support this as it was proposed that they were to become salaried employees of the state. However, the trend towards the specialist nurse in the later years from the 1970s did not reflect a social welfare ethos and may have been a further reason why there was not a registration of specialist nurses. The transfer of nurse education from the hospitals to tertiary education institutes occurred during the 1970s and the delivery of nursing care no longer predominantly relied on student nurses but was delivered by qualified nurses.

### **Tertiary Nursing Education**

The arrival of the Comprehensive nurse graduates into the hospital environment from the programmes in tertiary nursing education institutes occurred in the mid to late 1970s. The preparation of these nurses and the scope of practice were different from that of the hospital trained nurse. In particular the comprehensive nurse programme was inclusive of community and psychiatric components, which had not been included in the hospital training of nurses. However, in reality the role and scope of practice initially did not change particularly as the 'general' and the 'comprehensive' nurse were essentially undertaking the same role. It was my observation that there were difficulties with role identification. The move to primary nursing was not working as it was intended to, particularly with communication. The primary nursing approach to patient care meant that a specific group of patients in a hospital ward had a lead registered nurse who was responsible for planning their nursing care. Handovers about patient status needed to be obtained from different primary nurses rather than one as previously. Operational difficulties presented when several primary nurses wished to handover at a similar time for example to the night shift. Fewer numbers of night nurses created logistical difficulties. The previous teamwork approach included time spent with all patients, and those patients knew all staff including doctors. Some of the changes that primary nursing encountered were doctors who sought out the nurses to discover who knew the patient and if that nurse was unavailable then the information exchange did not occur. Ross

(2001) states that knowing one's role and having a mix of inexperienced and experienced staff meant that there was strong collegial support. She goes on to say that there are benefits for improved health care through the development of collaborative teamwork but one of the many barriers which prevent this collaborative teamwork is the lack of role clarity.

The graduates from the tertiary education institutions modified the focus from hospital training to that of a single integrated registration producing a generalist practitioner (Richardson, 2002). Hospital trained generalist nurses were not given the deserved recognition with their body of accumulated knowledge. Rather there came to be an unhelpful rudimentary comparison of which method of nurse education was better. It was not a sensible argument as a comparison was not appropriate. The idea of 'seniority' (which is part of a hierarchal system) in the nursing parlance began to take on a negative meaning because this idea was not possible in the primary nurse structure where all nurses who had a patient group were registered practitioners. Previously the communication flow that occurred also involved clinical learning for the whole team. From my experience as a nurse in a surgical environment, there were no opportunities for the nursing knowledge to be handed on without the former hierarchal structure. The term co-ordinator of nursing emerged, but generally people were unsure of the role and that included patients and other health professionals. As an example, the nurse co-ordinator may or may not have had a clinical role and there was no way of knowing this or what level of skill had been attained to assume the role, or indeed if a certain skill level was required at all. Doctors remained 'doctor' and that included student doctors through to consultants. I use this example of the retention of a title, as I believe that it is a powerful tool for keeping the public aware that amidst change there is constancy. Nurses were too ready to change their titles without mandate from their peer groups or the public and without research into its possible effects. The use of first names was encouraged from patients to address nursing staff but this did not convey professional status to patients. The Health Reforms that were a feature of the 1980s and 1990s affected nursing scope of practice and with the lack of nurse leaders during those years the environment was conducive to these effects.

## Shortage of Nurses

There was an increasing concentration of national health spending in the purchase of specialised services and technology from the period 1935 to 1980. Nurse numbers increased correspondingly, for example 7,763 in 1952 to 15,183 in 1969 (Gauld, 2001).

The current shortage of nurses throughout New Zealand is contributed to by the increase in specialist nurse positions. It is a mathematical equation that if specialist positions are being created for nurses then there are less numbers in the generalist pool to care for those people in the chronically ill category. The doctors in specialist practices and specialist positions confine their practise to the hours 0800 to 1730 usually and as a consequence the specialist nurses work those hours too. Earlier I identified that nurses undertake the role of other health professionals in an 'agency' concept. For example, special exercises that a physiotherapist may prescribe for patients that are undertaken by nurses when a physiotherapist may be unavailable in a rural/urban setting. In the rural/urban situation there are no nursing agencies to arrange replacement nurses. And it is an interesting scenario that there are people being admitted to the hospital who may require the services of a specialist nurse who is not on duty at the time of admission. Where funding is linked to services, a paper trail is required for invoicing. It appears that as nurses are not funded directly for their services then there is not the recognition of the actual services that they deliver. To refer to the previous example the physiotherapist may have a service contract with the hospital. The physiotherapist invoices on a fee for service but the nurse does not and so the input of the nurse is not recognised by the managers or funding bodies as the service is invisible. Conversely the physiotherapist may come into the hospital and undertake the procedure and it would then be identified as an episode of care. The nursing shortage is not a newly identified crisis in New Zealand. Cullens (2001) states there were other occupations such as teaching competing for young women and the situation today is that we have specialist positions within nursing as competitors as well. By this I mean that many students from the tertiary education institutions already have a specialist area they wish to pursue. As an example Emergency Department is an area that is very popular.

The service providers of care for the over 65 are consistently finding difficulties in recruiting registered nurses to staff these institutions. Teschendorff (2001) states that

nurses have a caste system that values thinkers more than doers. Therefore 'hi tech' practitioners such as Intensive care nurses are held in higher regard than the non-acute medical environment where curing is not the goal (for example geriatric nursing). A local example can be referred to in the throes of the health reforms of 1989. The then Director of Nursing at Southland Hospital proposed that nurses in the Intensive care unit be paid more than those in the elderly care services.

Over the next ten years there may be a great change in the profile of the nurse population. The establishment of nurse practitioners with autonomy in their practice should lessen the shortage of nurses because there will exist a formal process of referral from the nurse practitioners to other services. In the Nurse Practitioner Report (2001) one of the competencies expected is that as skilled and experienced practitioners they know when to refer their clients and patients to other professionals in the health services. The clarification in their scope of practice, which other allied health professionals currently enjoy, may encourage the increase in nurse practitioner numbers. In particular it will create the environment to have an ongoing relationship with the base of patients who will access care that is based on a holistic model. Ross (2001) says that in the rural situation health professionals working in a team situation offers communities an increased set of skills and support than that provided by single professional disciplines. Gauld (2001) says the health reforms introduced a competitive element amongst health professionals. I referred earlier to the situation in Southland where it was proposed that nurses in the Intensive care unit should be paid more than those in the long term care wards. The competitive philosophy introduced with the health reforms had filtered down to the nursing services and this was an example of the individual approach to care replacing what had been a team approach in the past. Ross (2001) states that for functions and roles to be effective the members of a team need to recognise their own contribution and work collaboratively. The disruption to a team concept in nursing was contributed to by the health reforms, as was the damage to the development of nursing autonomy, which required support from nurses to progress. The Ministry of Health produced a report called the "Ministerial Taskforce on Nursing-Releasing the potential of nursing" (1998a) and it was noted that practice nurses were not full team members in their situation, as they did not have the authority to refer to other agencies, to claim a fee for service, or to use diagnostic services. In the rural/urban situation where nurses practice with 'autonomy' in life saving situations, the authority to order a laboratory test is not possible. The section

on the health reforms and their consequences for nursing autonomy will be examined, with consideration to the requirements of a business environment that depends on a philosophy that does not include a holistic view of health.

## **SECTION TWO The Influence of the Health Reforms on the Southland rural/urban areas**

The Southland rural/urban area is the city of Invercargill with a population of 50,000 and a surrounding rural population of about 50,000, which is bordered to the south by Stewart Island off the Southern coastland, to the north by Lake Wakatipu at Queenstown, to the east by Gore and to the west by Tuatapere and Lake Te Anau. The delivery of nurse specialist services comes from the base hospital, Kew Hospital at Invercargill, and providing services to the rural population can involve many hundreds of kilometres of travel, (refer to Appendix: page 39) for both health professionals and patients. The Assessment Treatment and Rehabilitation centre for elderly health is retained at the hospital but all secondary elderly health care is provided by the private sector. Community Trust health centres have been redeveloped in many of the rural towns and if required there are helicopter services and aircraft services available for the transportation of people to the base hospital from throughout the province. There are also residential and private hospital services for the elderly in many of the smaller communities, for example in Winton and Queenstown there is a residential home for the elderly.

There will be a time in the future of New Zealand when the health reforms of the 1980s and the 1990s will be noted as an historically significant milestone for nursing. It was a time of change without apparent input invited from the nursing bodies. White (cited in Beekman and Patterson, 2003) states that nursing, as a profession was mainly not visible in setting the direction of the Health Reforms of the 1990s. The health reforms began in the early 1980s and their objective was the introduction of the 1990s competition and private management practices, which now abound in the public hospitals. "The introduction of the State Sector Act in 1988 meant new management systems in hospitals, while the introduction of the Public Finance Act 1989 meant that area health boards needed new financial practices and accountabilities" (Gauld, 2001, p.3). These accountabilities were identified in the Hospital and Related Services



Taskforce, which was also known as the Gibbs Report commissioned in 1988 (Gauld, 2001).

Beekman and Patterson (2003) contend that policy makers are influential in dictating nurses' practice. For example the use of unqualified care workers has occurred in other countries, which have gone through similar reforms within the health sector for example Canada, United States. Today it is common practice for health care assistants in New Zealand to deliver care. The Gibbs Report (1988) notes that there was a lack of clarity of hospital staff roles and responsibilities and the triumvirate management structure was seen to be acting as representatives of their staff groups rather than as managers. (Gauld, 2001). The triumvirate were the three administrators of the New Zealand hospital systems pre health reforms (the Matron, the Medical Superintendent, and the House Manager). These findings while factually correct did not consider the body of knowledge or the humanity involved in the nursing profession. It was disturbing that the nursing voices raised to debate these findings were silenced. My observation and experience in the hospital was that following the disestablishment of the triumvirate structure, the nursing support was no longer there. As well I witnessed the systematic removal of older/experienced nurses who had served in the local hospital with their skill and expertise over many years. The mandate for them was to change their nursing practice to suit the reforms. The essence of what nursing is as a profession was not a consideration by the reviewers, probably through their ignorance of the nurses' role, which from an economic viewpoint cannot be measured. George and Davis (1998) speak about the growing concern in nursing circles that traditional caring practices take second place to medical interventions. Beekman and Patterson, (2003) note that policy makers dictate nursing practice. As an example the reduction in numbers of bed stay days is dictated by policy and not patient need as assessed by nurses. The retention of a strong nursing influence in health care within the power base of hospitals is important to ensure that the use of technology does not compromise the care of the person. As Wilding (1982, p.27) states "Within hospitals, the emphasis has been on the development of high technology medicine rather than on the development of caring services." In 2001 there are still a number of anomalies in the health sector amongst which is an over emphasis on curative

medicine (Gauld, 2001). Allan and Hall (1988, p.33) say that it is time to move from the technological imperative and towards holistic models that have as their main focus a concern for people's lives. There are implications for nursing, as a profession when nursing services are responsive to the requirements of technology and specialisation and with a focus on curative medicine. The holism of their practice may become isolated and priority time given to the immediate requirements of technology. Richardson (2002) talks about nursing being described as an 'agency' for the undertaking of medical tasks and nursing rhetoric has become focussed on the bio-medical model. The measuring of blood pressure recordings can be a routine undertaking but it is debateable whether it is a nursing task and whether doctors would carry out recordings as often as they prescribe them for nurses to undertake. In the absence of the charge nurse role the evaluation of nursing scope of practice and its direction was overlooked. Agan (1987) states that holistic nursing can be a sensing level of knowing which may be subconscious or instinctual. There is an increasing role for technology in health care as the frontiers of treatment are peeled back to predominantly consist of intervention with instrumentation. However a glimpse of the burgeoning social problems redefined as health concerns cannot rely on the use of highly technical equipment to obtain a cure.

### **The Medicalisation of health**

Similar to the manner in which new nurse titles were invented new diseases and disorders have become accepted and driven by a medicalisation process. An example of this is Attention Deficit Disorder, which sees children treated by medication from doctors. I refer to this as an example because the holistic approach of nurses cannot be considered where nurses do not have a voice. Nursing input as a first option may dramatically assist the children without the need for drugs.

Wilding (1982) suggests in his book *Professional Power and Social Welfare* that professionals define needs and problems of people (such as alcoholism) and this will increase the involvement of medical professionals. An obvious example is the medicalisation of pregnancy as an illness and then shortages of personnel as claimed by

the health professionals can be justified. This means that as social ills continue to be defined through medicalisation, the numbers of professionals needed to treat people will never be enough and the health professional groups can always claim a shortage of numbers. Another relevant characteristic of the knowledgeable society is structural differentiation the increasingly sharp division of labour, which characterises mature industrial society. A range of activities previously undertaken by the family, the community or by informed groupings within it, become the province of experts (Wilding, 1982, p.14). The argument is that when people are freed from their rightful responsibilities for dealing with difficult children, for coping with handicaps, caring for dependents, people become less able to cope with other responsibilities that life brings. Professionalism can then mystify by making simple things complex (Wilding, 1982). Davis (1981) goes on to say that the major causes of death in the adult years are neither medically preventable nor curable but that there are social factors, which play a pre-eminent role. The increase of social ills that find their way into the health system continue to be absorbed but the effects on the nursing scope of practice continues to be ignored. The increase in diabetes is spoken of now as an epidemic and it is clearly related to social factors. The Ministry of Health has publications issued with strategies on how health professionals must act to reduce the impact of this on the health services. However, ill health appears with excess of food intake and insufficient exercise and to label diabetes as a health problem may inadvertently take away the individuals responsibility for their own obesity.

Twaddle and Hessler are two sociologists who argue that we should incorporate such modifications in our system of medical labelling; instead of talking for example about coronary artery disease, and thus associating the diagnosis solely with some aspect of bodily functioning, one would in an expanded labelling system talk of 'slow social support', diet deficiency, and low physical exertion disease affecting heart lungs and several other connected organ systems! (Richards, 1981, p. 342).

This quote acknowledges the holism of a person in relation to a disorder and it is that holism which nursing is concerned with in the care of patients.

## **Holistic Nursing**

The nursing profession seems to follow on in the specialist way of practice. This is in itself neither good nor bad but it appears to me that the art of nursing the whole person is being lost. There are many problems that beset those with chronic diseases and which dictates the delivery of nursing services. The nursing needs in a rural environment such as Southland are situated differently to urban areas of New Zealand. For example specialist nurse services are not available in an area where there is a shortage of specialist nurses and the health needs in the area are such that people need more generalist services. The Southland District Health Boards draft report on diabetes prevalence recommends the possibility of expanding the cardiac exercise class to include the diabetes patients. (Draft Diabetes Action Plan, 2003). This is a significant finding as the board recognises a generalist approach to services is needed in this example.

The following section can be viewed within this context then, for the future of health services in the rural/urban environment that is Southland.

### **SECTION THREE Future implications for Southland's rural/urban health needs.**

The implications for rural/urban nursing in Southland with the increased use of technology and the specialisation of medicine is an increase in the shortage of nurses. The Workforce Statistics (2000) report of New Zealand Registered Nurses, Midwives and Enrolled Nurses project indicates that there should not be a shortage of these nurses in the years up to 2010. It goes on to say however that should service demand increase by only 1% then a shortage will develop. It appears that there is no slowing down of the process of specialisation, and its effect in the rural situation will result in not enough specialist nurses to undertake that role. Cullens (2001) says that during the post-war years, an increasing number of hospital beds and the development of specialised wards, which required a decrease in the nurse to patient ratio, and medical advances, all contributed to a shortage of nurses. I would suggest that the development of specialised beds which doctors had for their patients as noted by Cullens in the post-war years has a parallel in the development of specialist beds today.

Contracts for the delivery of Nursing Services between health providers and the MOH state that specialist nurse input for certain conditions such as incontinence and ostomy are mandatory. This does not recognise that hundreds of patients in the rural/urban areas such as Southland have nurses who care for them professionally without the input from specialist nurses and it would be irresponsible if care did not get delivered while waiting for specialist nurses' input.

#### **Southland's Diabetic and Cardiac Specialist Nursing Services:**

I have worked in a hospital of a small population where there were two cardiac educators one for the community and one for inpatients. It could be expected that within a cardiac unit all nurses would be proficient at education for cardiac patients, so the decision to have both based at the hospital was questionable in the context of the rural/urban culture.

There was never any clarity of what each role was responsible for so the service was not always utilised. The wise use of existing nursing resources is of importance in the delivery of health care when inadequate services can be erroneously attributed to lack of funding. It is not only the many titles but also the variations on the title, which can add to difficulties in understanding a scope of practice. In Southland, a further example is where two Diabetic nurse specialists existed but no one was sure of their roles except one attended to inpatients, and the other to the outpatients in a rural/urban community. The institutional bias demonstrated the curative focus on both these roles rather than that of health promotion. The general public need to understand the role of specialist nurses as being health educators as well.

Diabetes is a multi – million-dollar problem in New Zealand with the related health costs of treatment. It has been described as an ‘epidemic’ driven mainly by demographic trends and increasing obesity in the population (MOH, 2002). However, Southland District Health Board (DHB) was reported as being reluctant to spend \$55,000 employing someone to co-ordinate and improve fragmented and deficient services. This request was top of the list of thirty-four recommendations put forward by the board staff to improve the fragmented and deficient services. However the chairman did not want to employ another person to ‘sit in an office’ and co-ordinate other people who ‘sit in other offices’ (Cosgriff, 2003). A summary of the recommendations are in draft form and include the following:

- Appointment of a diabetic educator and co-ordinator the latter position filling the missing link between providers of diabetes services, the patients and their families and carers that has been identified;
- Improve the education of health care providers;
- Improve education of health care providers in foot care to minimise the podiatrist workload due to a shortage of podiatrists in the Southland District;
- Encourage the utilisation of podiatry services;
- Develop screening programmes in collaboration with the Public health unit; and
- Continued support and development of Maori and Pacific Island programmes.

(Southland District Health Board, 2003).

As part of generalist nursing care pre comprehensive tertiary education, nurses included patient education about diet, attended to the care of patients' feet and particularly those with diabetes. The public health nurses at home visits, would educate on health as well which was usually of a generalist approach. Recent experience in hospitals shows that nurses view the care of the feet as the responsibility of the podiatrist.

The specialist diabetic nurses' scope of practice should have been clearly defined at implementation two decades ago and ongoing audits against standards would have supported the nurses and ensured service delivery met the needs of the diabetic population. I believe that this demonstrates again how the health reforms with the loss of nurse leaders in the profession still affect nursing. When these diabetic nurse positions were set-up it was driven by the needs of the physician and became a medical model service under-utilised and not responsive to the needs of the people in the community who have diabetes. The chairman is accurate with his statement about the risk of creating another position to co-ordinate other positions but it appears that nurses collectively have not contributed to voicing their concerns on what has been an unsatisfactory service since its inception. The summary of the current thirty-four recommendations for this service demonstrates that the absence of nursing autonomy in specialist practice has also been a contributing factor in this situation. It was common nursing knowledge that this service was unresponsive to the needs of the diabetic community but this was not responded to by either managers or the Director of Nursing. This was despite nurses being key providers of this service. Many of the current recommendations of the board were verbalised by nurses over the years, but not collectively enough to be heard. It is an indication of the reality that nurse leaders in professional issues are still silent and it is of concern that there is not a response to the voices of their peers. The inadequacies of this service are only responded to when voiced by a board over a decade later at the onset of what is being described as a 'diabetes epidemic'. The two cardiac nurses both based in a hospital despite the vast geographical area served by the health services showed the heavy influence of the curative model of care and poor workforce planning.

The shortage of General Practitioners in the rural/urban area of Southland will bring about change in the nurse role where advanced nursing practice may be a requirement to practice in the rural areas. However, there is a more immediate need in the rural/urban areas and particularly with the diabetic epidemic existing nurse skills can be utilised. Nurses in the past have shown their responsiveness to the changing needs of society and the Plunket and Karitane services are examples. Richardson (2001) says that the pioneer nurse in the 'back blocks' had considerable independence in their practice and that closer examination of the 'handmaiden' role of the past may show that independence and autonomy is not necessarily only linked to the concept of advanced nursing practice. If the holistic art of nursing is not promoted then there will be an increase in other professions pursuing this holism concept. For example, massage therapists provide the hands on unhurried contact with patients that nurses are 'too busy;' to provide. Ramsden, (2002) states that education of our potential professional nurses should be as wide, as varied and as well informed as possible. The current increase in specialisation of 'new conditions' does not give the variation in nursing care experience to the new graduate. I refer as an example to attention deficit disorder. The care of the chronically ill with enduring illness is necessary to develop an holistic nursing skill base.

Castledine (1995) suggests that the debate around specialist nurses has been concerned with the links to medical specialists and consequently developing the more medical aspects of their role that has an institutional bias and the concern of deskilling other nurses. My personal observation is that nurses do not have the authority of autonomous practice in the diverse areas where they undertake nursing services. For example, following a medical assessment of patients at an Accident and Emergency (A&E) department a nursing assessment should be protocol as part of the decision to admit a patient or not. Usually however it is the doctor who decides finally if a patient is admitted or not. My experience is that when patients from the long- term care hospital, which I managed, had an acute episode in the base hospital; their return was always dependent on the doctor's approval. Recently with an older friend in A&E I noted that she waited four hours for the doctor to discharge her as a formality. It was acknowledged by the staff four hours previously that her acute episode had passed and did no longer



need acute care. Incidental to this I noted that there was intense interest in the cardiac monitor from the nurses but no hands on care for the seven hours that my friend stayed in A&E She had sore heels and was not offered a change of position or taken for a walk. I use this example to illustrate that the isolation of rural/urban nursing was recognised in the former hierarchical structure and professional issues were discussed at regular meetings by nursing administrators in the areas where I worked. Senior nurse representatives from all the hospitals and community services who were in leadership roles attended. This forum allowed for informal contact and close attention to how the nursing profession was developing for local issues and concerns. An observation such as the one I made in A&E with my friend not attended to in nursing care could be addressed sensibly and not go through a protracted 'incident form' process that is the expectation of a generic quality culture. These meetings were structured but more importantly they related to collegiality and support for all who attended. This was an important means of staying united as a professional body not discussing how to meet the agendas of others but debating on what would be beneficial for those whom nurses care for. Information flow on the health policies of Government could be discussed at local level as well.

### **The restructuring of Southland's Public Health Nurse Services:**

From 1994-1990 the 4th Labour Government went ahead with radical policy changes in the health sector. The theories that accompanied this were about outputs, outcomes, multiple objectives and motivations (Gauld, 2001). The concern within Public Health nursing was the difficulty of measuring these performance indicators within a nursing philosophy whilst continuing to provide holistic care to the patients. A key role in the Public health nursing mandate was both the prevention of disease and the promotion of health. An erosion into the Public Health nurse scope of practice occurred locally as a consequence when firstly the Minister of Health, the Honourable David Caygill (1988) devolved the Primary Care budget to the Area Health Board level to promote service integration. Secondly, the next Minister of Health the Honourable Helen Clarke reversed this policy in 1989 and retained this budget within the Department of Health. Health

promotion and protection services remained a responsibility of the AHBs however. (Gauld, 2001). There were subsequent changes at a local level in Southland. In 1996 the Health Development Unit was situated at Southland Hospital in Invercargill. The staff mix included health promoters and health protection personnel and public health nurses. In 1997 they underwent a name change and became Southern Public Health Services and were relocated to the inner city. In 2000 they underwent another name change to become Public Health South. Each time there was a change the identity of the service needed rebuilding. The 1997 change was as a result of a split in the Public Health contract, a decision made by the then Health Funding Authority (HFA). This 'split' meant that the Public Health Nurses, and the Dental Therapists remained at the hospital (then known as the Crown Health Enterprise,( CHE)) from where their services were delivered as part of 'Well Child' services. Health Protection (regulatory function), Maori Health, cervical screening and health promotion contracts were given to Healthcare Otago, which subcontracted a private firm (Southern Monitoring Services) in Invercargill to provide these services. (This private firm had already been delivering all these services in the local community previous to the split in a contract with the Southland CHE). Consequently a geographical shift to offices in the inner city occurred excluding the Dental Therapists and the Public Health nurses as mentioned previously.

The annual report of the Southland District Health Board (2002/03) records that a disappointment has been the absence of the development of the plan to progress the Cardiovascular and Well Child strategy. This illustrates the consequences of what happened to nurses in 2000 as a result of more restructuring. The Public Health Nurses (15 in Southland) were asked to change their role to that of health promotion. Seven were to remain as nurses. The result of splitting the Public Health service is that there is very little contact between Public Health nurses and the rest of the Public Health Service for example health protection and health promotion. Public Health nurses had an important role in supporting families at 'risk' though this could never be 'measured' in 'outcomes'. Currently the Public Health nurses are still not working from the Public Health unit based at the hospital but work from the Health Promotion Team situated in the community. I use this situation as an example that the public health initiatives have grossly affected the

nursing scope of practice in particular by demanding that nurses actually cease practising as nurses. The change of titles causes confusion to health professionals and the nursing profession themselves. Currently as I write this there is another review of the Public Health Unit, which employs three nurses as well as other staff. There is no nursing representation from the nursing bodies while this review is being undertaken.

### **The 'Burton' Case:**

What is striking is the high technology bias of modern medicine in that almost half of all hospital patients are psychiatric or geriatric patients who stand to gain little from the developments on which modern medicine has concentrated (Wilding, 1982, p.27). There was a particular tragedy, which occurred in the mental health services in Southland where a patient in a highly acute state of mental illness was, through a series of system and staff failings, released into the community where he went on to commit matricide. "Burton was diagnosed with paranoid schizophrenia and killed his mother Paddy in Queenstown in 2001, shortly after being released from the mental health unit." (Cosgriff, 2003, p.3). There were further statements by Cosgriff in the same article saying that the unit had employed enrolled nurses in the acute area. This article of Cosgriff was written in response to an earlier Health and Disability Commissioner's Report about the case. In response to its (H&D) recommendation the MOH issued a directive to the Southland District Health Board that it stops enrolled nurses from caring for seriously unwell patients. There was concern from the NZNO that to remove enrolled nurses with 15 years experience and replace them with inexperienced staff may increase the risk to patient safety. This supports my position that it is not possible to have sufficient numbers of specialist nurses in a rural area that has difficulties attracting medical and nursing staff. The Chief Executive Officer of the NZNO argued that the recommendation from the report said there should be adequate supervision of the enrolled nurses in those areas, (which is required by the Nursing Council anyway) and it did not say to remove them (enrolled nurses). I would suggest that had the Council monitored their own requirements then ongoing supervision and clear scopes of practice may have possibly avoided the tragedy. The employment of Generalist and enrolled nurses is quite legal and under

monitored conditions quite a safe and responsible option for the patients. There was a letter written by the husband of the deceased woman to the NZNO. "The Burton tragedy was the result of individuals failing to perform to even minimum standards and it seems to me that the 'profession of enrolled nursing' emerged from the inquiry with reputation unblemished" (Burton, 13 Sept.,2003, p.2). He continued that it was more a matter of staff needing clear job descriptions each fully understanding their responsibilities and staff responsibilities being consistent with individuals' training and expertise. That had to be reinforced by adequate supervision as well, providing checks and balances to ensure work was being done properly.

There is an opportunity to assess the non-acute care needs of the psychiatric patients and provide educational programmes for the generalist and enrolled nurses in those areas. It is my belief that the holism of nursing relates to those people receiving psychiatric services also and that the specialisation of psychiatric nurses and doctors is not necessarily the only viable option for the patients wellbeing. Early holistic nursing responses can be as effective for the mentally ill as well. The expense of recruitment has not been revealed for psychiatrics in this region but I have observed for many years the process of bringing retired overseas psychiatrists to this region for a few months at a time, with no possibility of their patients developing a rapport with these psychiatrists. As well, the psychiatrists were given tours of the province and many other inducements to stay. The financial incentives that were included in these recruitment drives may have been better directed to up skilling the enrolled and Generalist nurses and provide the environment for the supervision of their practice by the mental health specialist nurses. This strategy would then ensure that the psychiatrists themselves would be supported in their practice from the nurses in the team. A further disappointment listed in the Southland District Health Board annual report (2002/03) includes the shortage of consultants, junior doctors, and specialist nurses. For a rural/urban population an alternative strategy is needed to address the staff shortages and acknowledgement that nurses can deliver professional services at a holistic level.

An article written by a group of mental health nurses says the issue for practice in mental health is not about being inundated with standards, guidelines and policies; but knowing firmly what is important and valuable; about knowing ourselves, as nurses and as a team. (Kai Tiaki, July 2003, p. 16). They used clinical indicators to measure if Australian and New Zealand College of Mental Health Nursing Standards of Practice were being achieved. This gave the nurses an assurance of meeting a high standard of care for their patients with the added safety of external input.

### **Southland's Geriatric Services**

With previous people experience of managing a hospital and rest home for the elderly sick and dying, I saw that environment as one, which mirrored those of the medical wards pre health reforms. It was in this environment that a great deal of nursing knowledge and experience was gained. The Health and Disability Commissioner Act 1994 recognised that those people who had disabilities did not require medical assistance but rather support to live with their disabilities. The term 'geriatric' for people over 65 was coined to accompany the specialist field of medicine dedicated to this age group, which was called 'Gerontology'. The first Gerontologist was appointed to the Southland Hospital in the mid 1970s. It is of interest that a second appointment occurred to replace the incumbent on his retirement from the position in the 1970s and since that time attracting the full complement of geriatricians has been unsuccessful. It is tacitly understood that eight is the number of geriatricians required to support the population and demographics of Southland, but according to the Ministry of Health there is not a proven formula for a patient to specialist ratio. Funding from the MOH for age related care is available for those over 65 years and the criteria includes documentation introduced that forms part of an intense assessment process. That is, there is documented proof of their perceived needs that if met would enable a better quality of life. The removal of elderly health services from the public hospitals reduced access by nurses to gaining and consolidating a skill base in the care of people with medical problems. These people were now deemed to be geriatric even though it is my experience that they were older people with enduring illness. Gauld (2001) describes the changes in service delivery for all the then CHEs in

New Zealand between July 1 to December 31 1999. Exits from maternity and aged care services and mental health services occurred but not in all of the AHBs. The reality of gerontology is that the advance of age affects all the bodily senses and functions to a greater or lesser degree depending on the individual. It is my view that in gerontological nursing there are no medical conditions that are age related. By this I mean that there are no diseases that are manifested after the age of 65, which have not for example existed in younger people. The health reforms however demand that people over 65 are grouped in specialised categories for identification purposes for funding.

### **Nurses as ‘agents’**

Nurses in hospitals provide 24-hour service and as other health professionals are engaged to provide services for patients (for example dietitians) these services are often delivered by nurses who provide 24-hour services. (It is interesting to note that there are now ‘nutritionists’ as well as dietitians). If nurses in the rural situation continue to use their resources to deliver health care for other professionals then there needs to be recognition of this by the NCNZ and a report about these issues and those of funding should go to from the NCNZ to the Ministry of Health. Another function of the NCNZ body is nursing education activity, which includes the quality assurance processes and also strategic policy development for nursing education. (News update, September 2002). An urgent evaluation of the nursing scope of practice in all settings is mandatory for the meeting of Quality Improvement systems in health services.

Two psychologists (Cooper & Clarke, 2000) undertook a study to investigate the training needs of specialist nurses for the psychosocial rehabilitation of patients after disfiguring injury or disease. They found that while nurses have been identified as the most appropriate health professionals to fulfil this role, it does not say who decided that. The article goes on further to conclude that while nurses do not feel as skilled at delivering psychosocial support, “They can very easily take on this role when given simple training and access to appropriate resources” (Cooper & Clarke, 2000, p.18). Ad

Hoc referrals from other health services to nursing services need criteria that includes nurses input on what that criteria should be. Cooper and Clarke's study does illustrate the perception that the nurse scope of practice is unclear to other professional groups thereby in this situation it may be more appropriate that the psychologists remain the providers of care and perhaps have their own care assistants to do so. My experience is that this referral procedure occurs over all the health professional groups creating a shortage of nurses in providing nursing care and services.

## **Conclusions:**

I have discussed the way that nurse specialists began to practice in this country without the traditional process of the public being involved. This in itself has meant that the specialist nurse role has developed without the clarity that was required for the public and health professionals to understand the role. In the large cities with dense populations the specialist nurse concept may not influence the generalist nurse practice as profoundly as it has in the rural/urban area of Southland, but the consequence of specialist practices in this rural/urban environment may eventually deskill the generalist nurse. The holistic care of generalist nurses is essential for the effective delivery of nurse services in the vast geographical area that is Southland. The increase of specialism in medical practice and the increasing use of technology, which demands a high skill level for their operation and maintenance will continue and nurses will need to define as a profession how much further they wish to develop their present role of specialism. In Section Three there has been a critique on the health services where nurses can make a real difference to improving the services to patients. Where recruitment difficulties abound, as they do in this rural/urban environment then alternative services need to be planned locally and generalist nurses up skilled to provide care that can be defined by criteria and supervision provided from the clinical specialist nurses. I gave an example of this in Section Three in relation to the 'Burton' case.

A team approach where all health professional roles are understood and monitored allows the different scopes of practice to evolve and provide the safety in practice for the patients and health professionals. I would add that this concept in my experience is more evident in the generalist nursing situation essentially because the nature of the nursing exposes the generalist to various situations that develop the 'knowing'. This is particularly so in the rural situations. With a more compartmentalised approach of the specialist, this 'knowing' may not develop.



I have discussed how other professions and the health reforms have affected the nursing scope of practice when the nurses role becomes an 'agency' to undertake the tasks of others. When this happens the nurse is unable to practice within her/his 'scope' for the delivery of care to patients. The case for a rural/urban scope of practice can provide for nurses in the rural/urban environment an opportunity to be up skilled in the various generalist areas where knowledge is mandatory for safe practice.

The expansion of health professionals entering the health environment, for example nutritionists as separate from dietitians, and massage therapists, may mean their numbers eventually become greater than those they are treating. Conversely, the nursing shortage shows no signs of easing and this can be as a consequence of not being able to attract them into the enduring illness areas such as elderly care. I have discussed the problem of 'shortage' in this rural/urban community that can be exacerbated by the disproportionate numbers of specialist nurses. It is my observation that the trend of specialisation is not generally the best option for the patient when entering the health system though that is not to say that it is not a good thing later on.

The power of the professionals was discussed along with a tendency to medicalise social ills that are really societal difficulties such as obesity and attention deficit disorder. This trend should it continue will create more nurse shortages by the volume of work that will be added. If health care is always going to be defined within a medical diagnosis for what are social and societal disorders then the traditional holistic nursing scope of practice will continue to be excluded and nursing care delivery will remain fixed in a medical model and under the control of the medical profession. I have identified that it does not need Nurse Practitioner status for the art of holistic nurse practice to be implemented but rather a commitment from nurses in this rural/urban environment to develop their own practice direction as a group. Richards (1981), observes that increasing disorders and a greater range of conditions enters the world of medical practice in the wider society while in the hospitals medicine diagnosis and treatment is related to body maintenance. Nurses in rural environments must have the skills to treat all conditions even those that acquire 'specialist' status in hospitals.

The theme through this research paper has been what I perceive as a lack of definition of the nurse scope of practice. The consequence of this is far reaching and has created a role for nurses that often include acting as agents for other health care providers who do not always take responsibility for care that they are funded for. Central to the concept of advanced practice is the notion of change that extends or expands existing boundaries, suggesting that innovation, revolution and reconstruction are part of the process. In contrast to this view an analysis of nursing in early New Zealand suggests an alternative hypotheses namely that, rather than pushing against the boundaries of other professions, nursing is in fact reclaiming elements associated with earlier nursing role. (Richardson, 2002). The pioneer nurses of New Zealand did enjoy autonomy of practice that was developed in the backblocks of New Zealand along with an independent nursing philosophy. I have discussed how this holistic nursing autonomy is absent in today's health environment due to the influences of the health reforms, the specialisation of nursing and the shift to the tertiary institutions for nursing education. Generalist Nurse specialists in disease management may be an option to assist those to better outcomes with chronic illnesses. The return of Public health nurses to a supportive role within the families would see a reduction in the diseases that are prevalent in populations such as cardio vascular and diabetes. Given this discussion and particularly the impact on nursing services in Southland I suggest a recommendation that may go some way to addressing the consequences of the chronic shortage of health professionals in the rural/urban environment. It will also ensure that the nursing scope of practice is understood by nurses themselves, other health professionals and most importantly the members of the public.

### **Recommendation:**

**A rural/urban generalist nursing scope of practice needs to be defined and then developed collegially with representatives from the nursing groups mentioned in Section three. Research on what constitutes the holistic art of nursing should be the base from which to develop this role.**

## **Rationale:**

Nurses' practice in a variety of settings so it is necessary to establish a benchmark of what constitutes holistic practice. Boundaries of scopes of practice are a necessity for nurses in the rural/urban environment particularly with the uncertainty of the role definition of specialist and generalist nurses that exists now. The evolution of nurse practice has stagnated in its natural development because of the absence of specialist nurse scopes of practice. When the profession is strong with clear practice guidelines then nurse research can be applied intelligently and the nursing profession develops its role and scope of practice. The complex health environment demands that nurses take back the control of their scope of practice in all areas where they deliver nursing services or external factors such as health reforms will continue to shape nurse practice. The rural/urban areas where nurses practice are particularly vulnerable to the vagrancies of the decisions made by those who do not appreciate that nursing is a profession whose usefulness cannot be measured in terms of inputs and outputs.

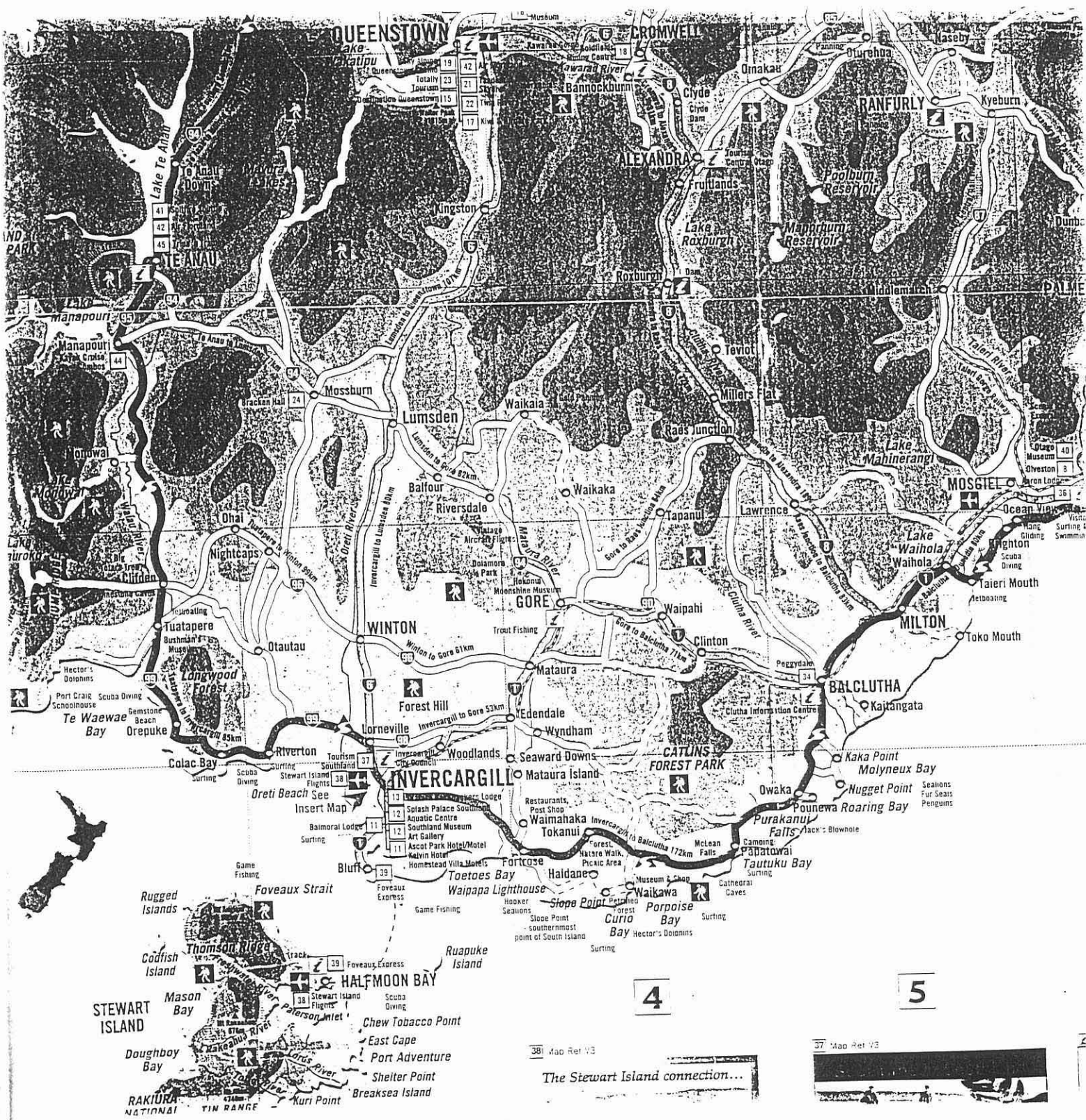
Trends towards specialisation have changed the nursing roles, and an increasing emphasis is on the co-ordination of the provision of care between health providers. Nurses themselves must discern if that is the role they wish to confirm for themselves. Nursing concerns and practice today are so diverse nurses in the future can look beyond their employment coming from traditional health institutions such as hospitals. Local government bodies may provide a more suitable environment to utilise their skills for health initiatives in the local community. As Benner and Wrubel (1989) state, a new vision of the nurse as knowledge worker is needed where clinical promotion programmes and participatory management will increase their power to shape their own practice. This will come about when nurses promote leaders within their own groups and support them to partake at policy level in Government locally and nationally

The demand for nurses in the international arena has increased as it is recognised that illness-orientated systems have failed. Nurses as interdisciplinary health team members

have always worked closely with others in health. They have been educated with a broad health focus and it is this strength, which will see the demand for their services grow. (The Nurse Practitioner, 2001)

It is essential in the health environment that nurses become proficient at presenting their professional practices to funding bodies with a goal to becoming independent practitioners in groups that deliver health care from independent nurse practices. This is not the same concept as Nurse Practitioners. Ross (2001) states that the opportunity to develop alternative ways of delivering health care is possible when open communication in a team concept is undertaken. Nursing scope of practice has its traditions in teamwork and from a return to this concept a rural/urban nursing service can continue to meet the requirements of the population's health.

**Appendix 1      Map of Southland and environs.**



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The Stewart Island connection...

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## References

Agan, R. D. (1987). Intuitive knowing as a dimension of nursing. *Advances in Nursing Science*, 10 (1), 63-70.

Allan, J., & Hall, B. (1988). Challenging the focus on technology. A critique of the medical model in a changing health care system. *Advances in Nursing Science*, 10 (3), 22-33.

Andrews, C. M. A. (2001). *Developing a nursing speciality, Plunket nursing 1905-1920*. Unpublished Master of Arts (Applied) in Nursing research paper Victoria University of Wellington, N.Z.

Baker, M. (2002). Non-directional counselling. *Annals Australasia Journal of Catholic Culture*, 113, 38.

Beekman, E. & Patterson, L. (2003). Nurse prescribing in New Zealand. Professional gain or political loss? *Nursing Praxis*, 19 (1), 16.

Benner, P. & Wrubel, J. (1989). *The primacy of caring: stress and coping in health and illness*. California: Addison-Wesley.

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

Bushnell, F. K. L., Cashman, S. B., & Fulmer, H. S. (2001). Community oriented primary care: A model for public health nursing. *Journal of Health Politics, Policy and Law* 26 (3), 617-634.

Carpenter, H. (1971). *An improved system of nursing education for New Zealand*. Wellington, Department of Health, Short-Term Consultant World Health Organisation.

Castledine, G. (1995). Delining specialist nursing. *British Journal of Nursing*, 4, 5, 264-265.

Castledine, G. (2001). Specialist nursing: The development of the role of the clinical nurse specialist in the UK. *British Journal of Nursing*, (7), 11-24 (9), 506-8

Cody, W. (1996). Drowning in eclecticism. *Nursing Science Quarterly*, 9 (3), 86-88.  
Collins Concise Dictionary Plus (1989). London: The Bath Press

Cooper, C., & Clarke, A. (2000). Psychosocial rehabilitation after disfiguring injury or disease: Investigating the training needs of specialist nurses. *Journal of Advanced Nursing*, 34 (1), 18-26.

Cosgriff, D. (2003), Enrolled Nurses told to ignore health directive. *The Southland Times*, September 3 p.3, Invercargill, NZ.

Cullens, V.J. (2001). *Not just a shortage of girls: The shortage of nurses in post World War II New Zealand*. Unpublished Master of Arts (Applied) in Nursing, Victoria University of Wellington, N.Z.

Davis, P. (1981). A sociologist looks at primary health care. In J. G. Richards (Ed.), *Primary health care in the community* (pp.339-347). Auckland: Longman Paul.

Emden, C. (1991). Ways of knowing in nursing. In G. Gray & R. Pratt, (Eds.), *Towards a discipline of nursing*, (pp. 11-30). Melbourne: Churchill Livingstone.

French, P. (2001). *A study of the regulation of nursing in New Zealand 1901-1997* Unpublished Master of Arts (Nursing) thesis, Victoria University of Wellington, N.Z.

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms*. Wellington: Institute of Policy Studies and the Health Services Research Centre, Victoria University of Wellington: New Zealand.

George, J. & Davis, A. (1994). States of health: Health and Illness in Australia. In P. McCabe (Ed.), *Complementary Therapies in Nursing and Midwifery: From vision to practice* (p. 24). Melbourne: Ausmed Publications.

Hessler, R., & Twaddle, A. (1977). The sociology of health. In J. G. Richards (Ed.), *Primary health care and the community* (p.342). Auckland: Longman Paul.

*Kai Tiaki. Nursing New Zealand*. (2003). Making the case for mental health standards. Volume.22



McGuigan, T. (1975). A health service for New Zealand. In Gauld, R, *Revolving doors: New Zealand's health reforms* (pp.43-44). Institute of Policy Studies and the Health Services Research Centre, Victoria University of Wellington N.Z.

Ministry of Health. (1998a). Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing. Wellington: Ministry of Health.

]Ministry of Health. (2002). *Diabetes in New Zealand. Models and Forecasts 1996-2011*. Wellington: Ministry of Health.

Nursing Council of New Zealand. (2000 October). *New Zealand registered nurses, midwives and enrolled nurses workforce statistics* Wellington..

Nursing Council of New Zealand.. (2001) *The Nurse Practitioner tm: Responding to Health Needs in New Zealand* Wellington.

Oxford Pocket Dictionary. (1975). Oxford: Oxford University Press.

Perkins, B.B. (1997). Shaping institution-based specialism. Early twentieth century economic organization of medicine. *Social History of Medicine*, 10 (3), 419-435.

Ramsden, I. M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. Unpublished Doctor of Philosophy in Nursing thesis, Victoria University, Wellington, New Zealand.

Read, S. (1994). Nurse practitioners in accident and emergency departments: Reflections on a pilot study. *Journal of Advanced Nursing* 19,4,705-716.

Richards, J.G. (Ed.). (1981). *Primary Health care and the community*. Auckland: Longman Paul.

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

Robbins, S.P., & Barnwell, N. (1994). *Organisation Theory in Australia*. Sydney: Prentice Hall.

Ross, J. (2001). *Role identification: An impediment to effective core primary health care teamwork?* Unpublished Master of Arts (Nursing) thesis, Victoria University of Wellington, N.Z.

Sandelowski, M. (1997). (Ir) reconcilable differences? : The debate concerning nursing and technology. *Image: Journal of Nursing Scholarship*, 29 (2), 169-174.

Shepherd, E. (2001). *Nursing Times* 97 (50), 23.

Southland District Health Board. (2002/03). *Annual Report for year ended 30 June 2003*.

Southland District Health Board Planning and Funding. (2003) *Reducing the incidence and impact of diabetes prevalence in Southland: Towards an action plan.(Draft)*

Teschendorff, J. (2001). Complementary care: Redefining nursing for the new millennium. In P. McCabe (Ed.), *Complementary Therapies in Nursing and Midwifery: From vision to practice* (pp.23-24). Melbourne: Ausmed Publications.

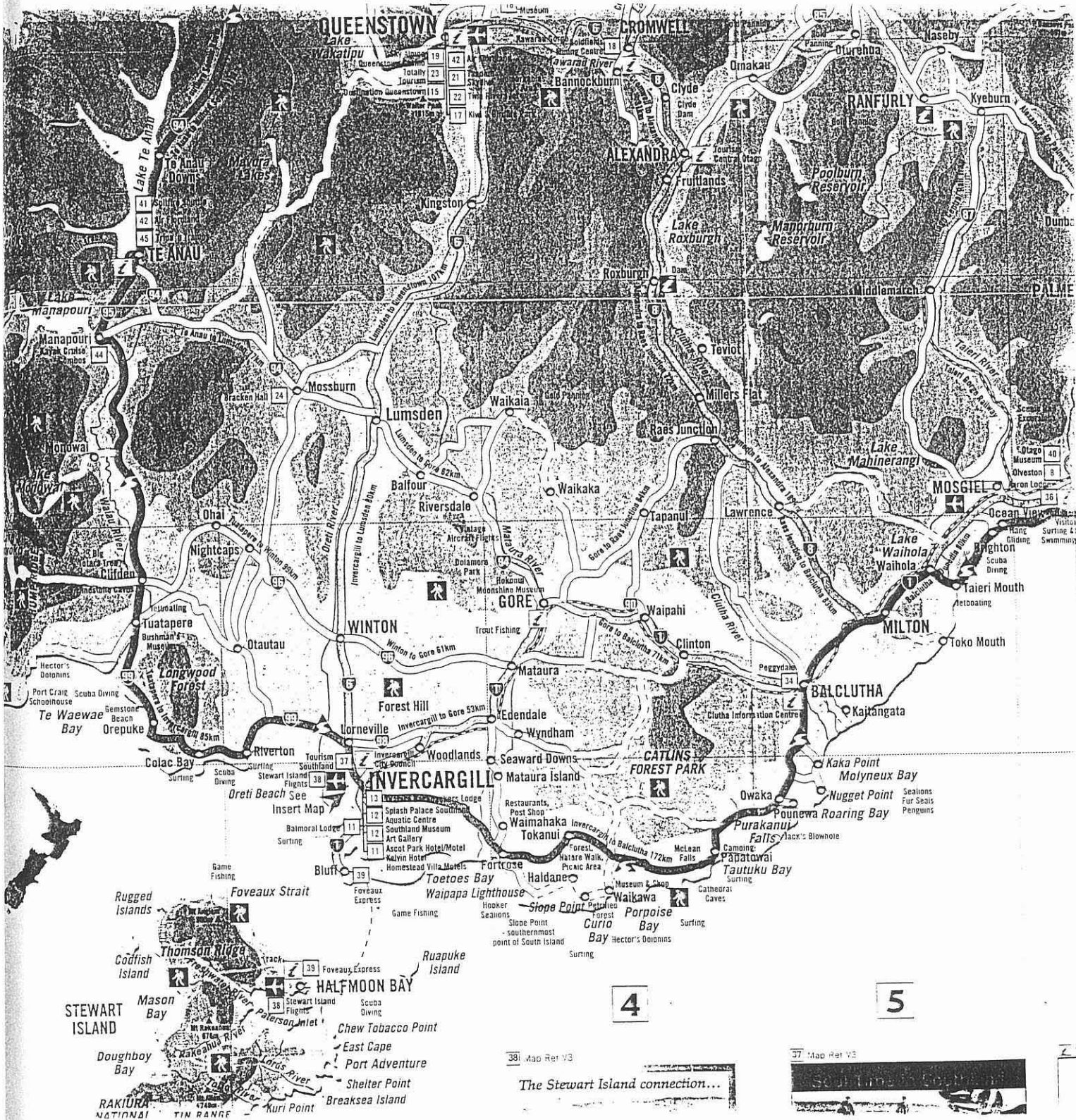
*The New Zealand Health Strategy*. (2000). Wellington: Ministry of Health.

The Southland Times (2003). *Burton backs nursing call*. (September 13, p.2). Invercargill, NZ.

Wilding, P. (1982). *Professional power and social welfare*. Great Britain: Routledge & Kegan.

Workforce Statistics. (2000). *New Zealand Registered Nurses, Midwives and enrolled nurses*. Wellington: Nursing Council of New Zealand.

Your APC fees. (2002), September. *News Update Nursing Council of New Zealand*, p.4.



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 The Stewart Island connection...

