

Profession and Place: Contesting Professional  
Boundaries at the Margins

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## Abstract

### **Profession and Place: Contesting Professional Boundaries at the Margins**

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There is considerable concern regarding the adequacy of rural health services in New Zealand, with much attention having been paid to issues of recruitment and retention of rural general practitioners. Rhetoric of 'crisis' is often utilised to raise political awareness of the problematic, but in fact, rural general practitioner recruitment and retention has been documented for about a hundred years. For about the same length of time nurses have been providing primary health care services in rural and remote places, often working alone.

Using the notion of nurses as a 'stop-gap' in the provision of rural primary health care until problems with recruitment and retention of rural general practitioners are addressed, is a rhetorical device that facilitates the under analysis of the role nurses play and the contribution that they make. The longstanding practice of rural primary care nursing in its various guises over the last century challenges the notion of nursing as a stop-gap.

Any investigation of health care in the contemporary moment needs to take account of the influence of biomedical dominance, an increasingly litigious mentality in relation to health care, a shifting focus towards primary rather than secondary health care, and the positioning and re-positioning of health professionals within the neo-liberal state. The very existence of nurses working as the first point of contact in the health care system, with success over time in so far as they do not provoke undue litigation, and appear to deliver an appropriate service must raise questions about who can claim the right to be a primary health care provider.

Based on qualitative research conducted in New Zealand and the Western Isles with rural primary care nurses and Family Health Nurses respectively, this thesis explores the ways that nurses construct flexible generalist professional identities that challenge traditional inter and intra-professional boundaries. In the New Zealand case, rural primary care nurses negotiate the boundaries between nursing and medicine, those within nursing itself, and also those between nursing and paramedic work. Nurses perform this boundary work by negotiating self-governing 'appropriate' and 'safe' professional identities. In the Western Isles case, the introduction of the newly developed role of Family Health Nurse serves to highlight the problematic nature of inserting an ostensibly generalist nursing role beyond the rural.



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## Preface

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Much, although not all, research is stimulated by conglomerations of pieces of our own experience. This research is no exception. As a seventeen year old, straight out of school in the mid 1970s, one of the doctors that lectured me during my nursing training said that one of the most important things that a nurse can do is learn the terminology used by doctors. Although I felt rather uncomfortable about this statement, at the time, I had neither the tools, nor the skills to contest such a view of nurses and nursing. This statement constitutes the beginning of my journey, the point of sensitisation, towards a deconstruction of the ways in which professional boundaries are constructed, negotiated and maintained through discourse.

A period of three years spent on the Chatham Islands, loosely involved in health care stimulated the second strand in the conceptualisation of this project. The breadth of the role of health care practitioners there ranged well beyond the scope of traditional role boundaries. It is the way in which professionals construct, negotiate and maintain their identities in rural settings, the ways in which profession and place co-construct each other that I find most interesting.

The final, and crucial element in this research cocktail is the overt focus on nurses. A period spent engaged in the study of gender, culminating in a masters thesis exploring the professional identities of town nurses in a radically restructured hospital environment, as well as my own background in nursing were the prime motivating forces in thinking about the nursing profession and its relation to place. The focus here is firmly on nursing professionals because I am concerned about the way that nurses have been under represented in policy, seeming to often remain subordinated to medicine and the bio-medical model.

# 1

## **Introduction: Of nursing, identity, profession and place**

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*'I'm sick of being seen as a stop-gap'* – such were the heated words of a frustrated rural nurse working in a predominantly nurse-run health centre. She is referring to the perception that a primary health service is not a 'real' service unless it contains at least one doctor. She perceives that the service that she and her colleagues provide is seen by some doctors and policymakers to be temporary until 'rectified' by successfully addressing the problem of the recruitment and retention of rural general practitioners in New Zealand.

Little attention has been paid to professional or semi-professional work in rural areas and very little attention to nurses who are a very significant occupational group within healthcare. The relative absence of nurses and nursing in the literature reflects the lesser influence and power that nurses have as an occupational group (Halford et al. 1997; Lupton 2003; Witz 1992). Indeed the invisibility of nurses is so pervasive that Oakely (1984: 24) says that during a "15 year career as a sociologist studying medical services [she had been] particularly blind to the contribution made by nurses to health care".

This lack of interest, and the perception of the subordinate position of nursing, is not confined to the academic literature, as an interaction with a healthcare manager shows. Near the beginning of this research investigating rural nursing I had a conversation with a manager at one of the New Zealand District Health Boards. We discussed the problems of providing rural health care, most particularly the shortage

of rural doctors. I suggested that nurses may be able to extend their roles to address some of the need for rural health care. Her somewhat extreme response was that she thought that nurses were just married women who want a bit of part-time work and little responsibility. Interestingly the manager herself was a married woman who worked full-time in a responsible job. Clearly her identity as a married woman did not preclude her pursuing full-time work or responsibility, but there was something about nursing that she felt did. The manager's perception was quite at odds with what I already knew of the, admittedly small, group of rural nurses whose work I planned to research and this perception also raised questions about rurality, gender identities and professional identities.

This chapter is divided into five main sections. The first identifies the research questions that will be addressed throughout the course of the thesis. In order to set the scene for this research, the second section provides a brief context of the New Zealand health care environment, rural health care and the positioning of the nurses who participated in this research within that environment. This section also looks at the rising profile of primary health care and the potentially enhanced place of nursing in this changing climate, as well as providing a brief introduction to the broad philosophical and theoretical attitudes that I bring to the thesis. The third section looks at limitations in the existing literatures, while the fourth looks in more detail at the specific theoretical frameworks that are utilised in the thesis. The fifth, and final section outlines the thesis structure.

### **Research Questions**

As a result of a brief informal pilot study and from attendance at the first conference of rural nurses in New Zealand, I was interested to explore the construction of the

professional identities of a relatively small group of rural and remote nurses who work predominantly alone and whose professional identities cross boundaries between medicine and nursing, nursing and paramedic work, and intraprofessional boundaries within nursing itself. The rationale for wanting to investigate this group was so that I could see what nursing does in the absence of close proximity with other health care practitioners, which in turn generates an understanding of what nursing, or perhaps some nurses, can and do contribute to primary health care more broadly.

This research problem is addressed in the context of a perceived crisis in the provision of rural health care, and also the changing face of primary health care which is beginning to move away from a focus on biomedicine and medical care towards a focus on maintaining wellness via health promotion. While interprofessional boundary disputes between medicine and nursing are of long standing, nurses claim to be well equipped to deliver this latter type of health care. The type of rural nursing investigated here appears to offer a model which has the potential to decrease fragmentation in primary health care delivery and ensure follow-up due to nurses highly visible and approachable position within the community. Very broadly stated, the research questions are:

**1. How are nurses currently functioning to deliver primary health care in rural places?**

I am not interested in merely constructing a list of tasks that rural nurses carry out, but rather I am interested in the ways that nurses “make sense” (Wetherell et al. 2001) of their flexible/generalist professional identities in rural and remote areas; in how they construct and negotiate these identities. Beyond discussions of rural gender identities, how do nurses make sense of this conceptually complex, (perhaps overdetermined),

flexible positioning? How is a hybrid professional identity negotiated in rural space? Hollway claims that “people have investments ... in taking up certain positions in discourses....It is not necessarily conscious or rational. But there is a reason” (1984: 238). Conceptualising the ways that people take up positions in discourse in this way avoids the use of the idea of ‘choice’ as if a rational, self-aware, subject does the choosing. The notion of a unitary, self-aware subject is counter to contemporary understandings of the non-unitary character of subjectivity. As Hollway argues, “ a term like ‘choice’ does not convey the complexity of the causes for action” (1984: 238). What discursive investments, then, do nurses utilise in the doing of contemporary rural professional identity?

## **2. How do feminised professional work and rural space influence each other?**

I want to move on from simply mapping profession on to place as if place/space is a blank slate, but rather to investigate the ways that profession and place are co-constitutive. Geographers, while having paid attention to a number of forms of feminised work (see Pratt 1999), have ignored nursing, with the recent exception of Pratt and Kirby (2003). Conversely, those who have an understanding of the implications of the way the development of nursing has occurred do not tend to take spatial dynamics into account. It is the crucial mix of an understanding of the development of nursing as a feminised profession, and the way that that development is reconstituted spatially, that forms the core contribution of this thesis to existing knowledge about the construction of the profession of nursing in relation to space/place.

### **3. What potential is there for the model of rural nursing to expand beyond the rural into the urban?**

Drawing on the understandings generated in responding to the first research question which show nurses to be successfully managing autonomous professional identities which are both governed and self governing, the question remains as to whether these professional identities are place specific. That is; is it that these flexible generalist professional identities can only be practised in rural spaces, or at the margins?

#### **Setting the Scene**

The problematic nature of the provision of health services in rural communities is widely acknowledged, but in New Zealand rural areas have had to negotiate processes of restructuring since the early 1980s that complicated the health care arena. New Zealand is famous, or perhaps infamous, for its self-imposed process of structural adjustment. This process was prompted by several very significant international moves that ‘shocked’ the New Zealand economy in the 1970s. According to Dalziell and Lattimore (1996: 15-18) these shocks consisted of firstly: the entry of Britain into the EEC (which negatively affected the ready market that New Zealand had enjoyed for wool, meat and dairy products), and secondly a hike in the price of oil. Coupled with these international factors, rising inflation and increasing levels of unemployment nationally, prompted a radical response on the part of the new 1984 Labour led government. The policies enacted by this government promoted, among other things, the primacy of a deregulated market as a key to New Zealand’s economy becoming internationally competitive. Along with more-market policies were also explicit initiatives to “roll back the state” (Kelsey 1993), and thus fulfil the neo-liberal objective of a “minimalist state” (Larner 1998: 5). But Larner also makes the

important distinction between ‘government’ and ‘governance’ and suggests that less government does not necessarily mean less governance (1998: 12). As will be shown during the course of the thesis, the issue of ‘governing’ is a complex and often individually internalised process.

The above policies were presented to the population of New Zealand as the *only* alternative to an unhealthy economic situation. In this regard, Brodie suggests that the “restructuring discourse attempts to depoliticize the economic by representing market-driven adjustment as self-regulating and inevitable (1996: 388). The focus on the inevitability of ‘market-driven adjustment’ has been part of the rhetoric which has paved the way for the government to push through sweeping, and cumulative changes very rapidly. This rapidity has led Barnett (1999: 4) to suggest that the process has been undemocratic (see also Lewis and Moran 1998).

The impact of restructuring on rural New Zealand, particularly agriculture and farming, where many of the subsidies that had protected these producers from the vagaries of the market have been lost is well documented; see for instance, Kelsey (1997: 95-96) and Le Heron and Pawson (1996). Industries located in minor urban areas have been faced with the prospect of closure or relocation in order to find even cheaper sources of labour to maintain profit margins in the new highly competitive economic climate. Country towns have been affected in at least two ways; firstly, by the flow-on effects from lowered returns of the agricultural and farming sectors and secondly, from the restructuring of the service sector in general. Institutions such as banks, the Post Office, and branches of social support agencies have been restructured which has often resulted in their withdrawal from towns. Kearns and Joseph (1997: 21) note that although loss of services and population decline have been part of rural

communities since the end of World War Two, the rate of decline has sped up since the mid 1980s with restructuring initiatives.

Although some of the most far-reaching changes in the health sector occurred in and after 1993 (Ashton, 1999), population-based funding formulae in different versions since 1984 (for the latest version see MOH 2004) have, increasingly, shifted health funding north and away from rural areas. The process of centralisation of, particularly, specialist hospital services has tended to shift services away from smaller locales. This has been especially evident in the case of general surgical services, with four town hospitals in southern New Zealand losing surgical services between 1993 and 1999 (Barnett, 2000: 11).

The southern region of New Zealand has been strongly affected by the northward drift in health funding. In 1998, in the face of an increasing budget deficit, Healthcare Otago, one of the two southern health authorities, withdrew from the provision of rural health services (Barnett, 2000: 9). The onus fell on the local communities to assume responsibility, or not, for their local health services (Barnett and Barnett 2003). A central government fund, the Community Trust Assistance Scheme, was set up to finance local initiatives. Gauld (2001: 160) indicates that of the \$18 million that had been allocated to affected communities by 1999; about half of this sum went to Trusts in rural southern New Zealand. But in even more remote areas of New Zealand it is often solo practitioners who provide primary health care services.

In some areas of rural and remote<sup>1</sup> New Zealand, nurses currently provide comprehensive primary health care services to the local population. The ways that nurses function as health care providers in rural areas has had a much lower profile than that surrounding general practitioners (GPs). In terms of the issues surrounding the employment of rural health professionals, there has been increasing attention to problems with recruitment and retention of rural general practitioners. But these problems have been documented since the early 1900s in New Zealand, which indicates that this shortage is not easily addressed.

Having initially been caught up in the rhetoric of ‘crisis’ in rural health care, I began this research by assuming that nurses were beginning to play a larger part in the provision of rural/remote primary health care than was previously the case, and that this was due, at least in part, to an increasing shortage of doctors willing to work in rural areas. Shortages of rural doctors and difficulties with recruitment and retention have been documented since the early years of the twentieth century. Dow notes that even in spite of subsidies, it was difficult to attract and keep reliable and sober doctors in these poor paying roles that were often located in Māori communities (1995: 82). Further, in an attempt to make rural areas more attractive to general practitioners, Special Medical Areas were set up in more rural parts of New Zealand in the 1930s in areas in which general practice was not economically viable (Kearns 1991: 520).

Thus, it is perhaps more accurate to say that there is a perception (held by, for instance, the public, the media, as well as some practitioners), that there is a contemporary crisis in rural health care provision, but that any ‘reality’ about this is

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<sup>1</sup> I have made a conscious decision not to attempt to define either ‘rural’ or ‘remote’ since in spite of numerous attempts by policy makers and social scientists to define these terms the definitions remain problematic (see also Lawrence 1997). I am more interested in perceptions of rurality or remoteness rather than any objective measure of spatial division. Indeed, when the Western Isles are considered (as they are in chapter seven) perceptions of rurality and remoteness are seen to be very different to what New Zealanders consider to be remote or rural.

hard to locate since the adequate provision of health care is highly subjective. Patient expectations change, as do biomedical techniques, legislation, nursing care, funding, telecommunications, and accessibility in rural and remote places. So while in some rural areas there is increasing use of nurses as primary health care providers, the core rural and remote nursing staff is of long standing. Nursing can be seen to have come more into public discussion in recent times for a variety of reasons that will be discussed later, but nurses have actually played a key role in rural and remote healthcare in New Zealand from the earliest days of settlement by Europeans. The very raised visibility of rural nurses also serves to bring them into discourse as governable subjects.

Registered nurses<sup>2</sup> who work in these rural and remote areas practise well beyond conventional scopes of nursing practice. When I asked the nurses that I interviewed what their work role consisted of, many of them just laughed and said “everything”. Some parts of their roles could fit broadly under the umbrella of urban practice nursing (those nurses who work with general practitioners in clinics), and some under that of district and or public health nursing (nursing carried out in the community including schools). There is also an emergency nursing component (pre-hospital care). Rural and remote nurses do not fit neatly into any of the traditional nursing categories and they are employed under many different nursing titles, but for ease of reading I call all of them rural primary care nurses, or simply nurses.

Rural primary care nurses’ work encompasses everything from the patient with a sore throat, to the aftermath of a high-speed car accident, as well as occasional psychiatric work, dentistry and veterinary work, fairly frequent counselling, with some maternity work as well. There is also a community building component for

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<sup>2</sup> Registered nurses are those who have carried out a three- year course of instruction.

many nurses. Nurses' roles also encompass administrative tasks, such as filing, ordering stores and equipment, search and rescue co-ordination (in some cases), the evacuation by helicopter or ambulance of patients requiring hospital admission and organising car and clinic maintenance. Some nurses even organise relievers for themselves if they want to have time off and they are not always successful in this endeavour. This range of patients and tasks is never seen/done by the same nurses in urban nursing practice.

As well as being clinically flexible, rural/remote nurses are often also temporally and spatially flexible. Temporal flexibility occurs when nurses participate in on-call rosters for up to ten days at a stretch. Temporal flexibility is also evident when nurses meet fluctuating demand for their services during peak holiday times in tourist destinations, when seasonal workers enter the area in which they work, and also inflows of recreational users such as whitebaiters<sup>3</sup> and fruit pickers. Spatial flexibility is evident when nurses take on other nurses' geographical work areas to cover days off.

While not every rural primary care nurse will practise to the degree of flexibility exhibited by the nurse who saw the dog as a patient on New Years day, the most extreme examples are those nurses who function in rural/remote areas, predominantly without doctors. While Coster and Gribben (1999: 35) indicate that the idea of an "independent nurse practitioner is as archaic as the idea of a solo GP" and that "neither is an appropriate response to the diverse health needs of populations", rural and remote nurses have in fact functioned largely alone for decades. It is these nurses who are the focus of this research.

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<sup>3</sup> Whitebait are small fish caught in nets in rivers, on a seasonal basis.

Rural primary care nurses practising in areas of the South Island of Aotearoa/New Zealand and off-shore islands occupy professional roles that are distinct in many ways from nursing roles practised in urban areas. The conjunction of profession and place gives rise to hybrid professional identities that span boundaries between medicine and nursing, nursing and paramedic work, and intraprofessional boundaries within nursing itself. The extraordinarily flexible performance of feminised professional work both contests and reinforces stereotypical notions of rural femininity and gendered work. Investigating how nurses make sense of these nursing roles increases understandings of the construction, maintenance and contests over professional boundaries. It also enhances understandings of the ways that profession and place are co-constitutive, as well as contributing to discussions surrounding the potential that nursing has to play a larger part in primary health care more generally.

The idea of flexible labour is not new and is usually associated with discussions of neo-liberal economic theory (Crompton 2002). Flexibility in these terms means the intensive management of workers in order to achieve efficiencies in production. While in one sense this flexibility is precisely what is happening here, the flexibility of the labour arrangements entered into by rural nurses in New Zealand well predates these literatures, with nurses occupying these flexible roles as far back as the 1900s (Rattray 1961). Rural nurses have maintained flexible, generalist roles, while urban nursing has become more specialised. While rural nurses' occupational flexibility does share some characteristics of the above idea of flexibility, simple notions of numerical or functional flexibility, as described by Walby et al. (1994), do not capture the "investment" (Hollway 1984) that rural nurses have in their work. The complexity of that investment is hinted at in the following interaction. A nurse gave a presentation describing her work at a conference of rural nurses and rural doctors in

mid 2002. Following her presentation a doctor stood up and said that he thought what she was doing was actually missionary work. This scenario evokes the concept of vocation, which was, and perhaps can still be traced into the contemporary construction of nurses' professional identity. Clearly then, the way that flexibility is embodied in rural primary care nursing is more conceptually complex than analyses of labour market flexibility allow. Some of this complexity is evident in Reverby's (1987) analysis where she argues that, "nurses are neither the poor victims of hospital and physician oppression and the impotent descendants of a long line of women healers, nor the victors in a difficult and long struggle to gain professional recognition and status. Their history is more complicated than such simplistic analyses, built on either anger or romanticism" (Reverby 1987: 6).

The rising profile of primary health care and the place of nursing

Although the majority of nurses are employed in hospitals, the current political will in New Zealand is towards a greater attention to primary health care and its potential as a means of preventing future ill health, and therefore cost to governments. The Alma Ata Declaration of 1978, arising from the International Conference on Primary Health Care in that same year, has been widely understood to be the stimulus for this relatively recent shift in focus. Item eight of the declaration states that:

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally (WHO 1978).

The Alma Ata Declaration has been drawn on by many governments to formulate primary health care policy as they recognise the important role that primary health care plays in improving population health outcomes and addressing inequalities in

health. In the face of increasing specialisation and the high status of specialised health care work, shifting the balance to a focus on generalist primary care work is inherently challenging. In *The Primary Health Care Strategy*, well-trained primary health care nurses are identified as “crucial to the implementation of the Strategy” (2001: 23). This point has been taken up by nursing groups, who have argued that nursing, in its body of knowledge and philosophy, is more than ready to meet this shift in focus (Carryer et al. 1999).

*The New Zealand Health Strategy* (2000) identifies five service delivery priorities that the government wants to see the health sector focus on, and one of these five is accessible and appropriate services for people living in rural areas. In *Implementing the Primary Health Care Strategy in Rural New Zealand* (2002), upskilling nurses is identified as one of the ways to attempt to address heavy workloads, but particularly, unreasonable rosters. But the areas that this research is based in are not amenable to these strategies since in most of them there are no doctors and if there, they are already doing rosters with nurses. It is the nurses who are doing the onerous on-call duty, with little flexibility for change. The ideal, as articulated in the above strategy, is for “on-call rosters not to exceed 1:3<sup>4</sup>, and with a clear preference for 1:4. These aims, while being a minimum for sustainability of high quality services, are also likely to aid recruitment” (ibid: 29). The above document does note that there are a few remote areas that will be the exception to this plan and they will need “special consideration and assistance” (ibid: 29). The document gives no indication of the number of remote areas, or their location, but that they are few in number and that they have particular and unique needs. It is these very areas, the margins, where

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<sup>4</sup> The values 1:3 and 1:4 mean one night or weekend on-call and three or four off call.

different articulations of health care work are simultaneously required and produced, and reproduced.

The reorientation of the health system towards primary, rather than hospital care is a key philosophical shift with long-term population health gain as a goal. While attention has been paid by nurses, doctors and public health practitioners to the importance of focusing on primary health care (PHC) for over thirty years, it is only in the last five or so years that primary health care has come to be of central importance in government health policy (see for instance *The Primary Health Care Strategy* 2001). Traditionally PHC has been delivered in New Zealand via GP practices funded by government subsidy and patient co-payment, hence primary health care is not free to the user (Crampton et al. 2001: 1492). Primary health care has been variously defined ranging from the broadest notion including public health initiatives, politics and processes, to the narrow focus on “health service provision within the formal health services” (ibid). The vision for the development of PHC in the *Primary Health Care Strategy*, is for a service that places a greater “emphasis on population health and the role of the community, health promotion and preventative care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fees” (2001: 7). Third sector (non-government and non-profit) health care organisations have been operating in New Zealand for over twenty years. These were largely set up in deprived urban areas and rural areas where often there was a predominantly Māori population (Crampton et al. 2001). One of the key features of these third sector primary care organisations was that the general practitioners are salaried and the organisations funded by population-based capitation funding. This system of funding provides an incentive for the use of health professionals in different ways particularly nurses (Crampton et al. 2001), since

traditional funding streams in general practices act as deterrents to the more extensive use of nurses (Carryer et al. 1999).

Although the restructuring that the health sector in New Zealand has been engaged in has been ongoing since the early 1990s, this latest shift in orientation has involved adjustment and change in work practices, more so for those working outside of hospitals than those working in them. Key shifts have involved moves toward more community representation on health boards, a commitment to community consultation, and openness to the contribution of many health care providers (see Neuwelt and Crampton 2005), moving beyond a focus on doctors and opening up a potential space for nursing to gain a higher profile.

This research sits at the intersection between geography, gender, nursing as a profession and government health policy, all of which are crosscut by, and imbued with, politics and power. The ways that geography, gender, nursing and health policy are 'read' is situated within the broad approach of post-modernism. A "post-modern attitude" (Cloke et al. 1991) poses a challenge to modernist approaches that seek to provide grand, totalising theories. Totalising enterprises are claimed by post-modern theorists to obscure 'difference', by rendering invisible those issues and peoples who do not fit the totalising theories. Thus, one of the crucial ways that a post-modern theoretical approach differs from a modernist one is its attention to difference<sup>5</sup> rather than homogeneity. It is this lens of difference that is one of the contributions of this thesis, since the perception of nursing as an homogenised entity is potentially problematic. Often when changes occur for registered nurses they are assumed to affect all members of the occupational group in similar ways regardless of their geographic location. Rather, different professional identities are constructed in

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<sup>5</sup> Care needs to be taken in acknowledging difference so as not to assume that those who inhabit a particular category of difference, say gender, are alike. Rather, they may share some characteristics and not others.

different locales by virtue of the differential contexts and scopes of practice (with regard to nurses in particular, see Thompson 2001, 2005). Factors such as health sector restructuring, changes in nursing registration requirements, the introduction of new roles such as Nurse Practitioner, selective rural depopulation<sup>6</sup>, shifts in the ways that governments focus and control health care expenditure, and shifts in the way that nursing is discursively constructed by both its practitioners and by nursing and government policy makers all have different implications for professional identity in the rural setting. The task of this thesis is not to answer questions about all rural registered nurses in all places and in all times. But, importantly, the more modest task envisaged by a post-modern approach is to “contemplate the human world less in terms of ‘grand theories’ and more in terms of *humble, eclectic and empirically grounded* materials” (Cloke et al. 1991: 171. Emphasis in original). This thesis, therefore seeks to look in depth at a relatively small group of similarly situated rural registered primary care nurses.

To discuss nursing is to discuss gender. Ninety four percent of nurses in New Zealand are women (Statistics New Zealand 1998: 96). So although four of the participants in this research are men, they still practise in a feminised profession. The way that rural nurses’ professional identities are constructed is, hence, a complex mix of feminised work/gender, geographic locale and the particularities of individuals. Inevitably, then, this research spans literatures and theoretical frameworks. It is of key importance to attempt to move beyond the perception of space as merely a passive, inert, apolitical, “container for gender and other social relations” (Little 1997: 140). Hence the aim is not to map rurality on to professional identity, or vice versa, but to see space/place and professional identities as co-constitutive.

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<sup>6</sup> Rural depopulation is not a geographically consistent trend in New Zealand, rather it is influenced by a large number of factors, for instance, the upsurge in wine and olive growing in some rural areas and the increase in tourism (Cant 2002: *pers. comm.*).

I am interested in this thesis in the materiality of place and the concept of space, but most particularly in the ways in which space, place, and nursing mesh to form a discursive space of possibility, but a space of possibility that highlights the workings of power. As Massey (1994: 254) says, space is “constituted through social relations and material social practices”, thus I am interested in space, place and profession as relational rather than discrete and bounded entities, and as central to the workings of power. This conception of the relations between space and place moves away from an understanding of space as absolute, as earlier forms of analysis might have conceptualised (Hubbard et al. 2002). Along with many other geographers (Crang and Thrift 2000; Keith and Pile 1993; McDowell 1996, 1999; Massey 1994), I see the materiality of place as not simply a physical location, but again, as relationally constructed by the flow between everyday practices, material landscapes and wider social, political, historical and cultural understandings and meanings that come to be associated with places. Places also come to be made or produced as part of processes of identity formation and reformation. It is by engaging with contemporary theorisations of space that we can analyse the relationship between place and identities (Keith and Pile 1993). Conceptualising spaces and places in this way means I see them as separate, and related at the same time (although that is not to deny any sense of materiality) and in this thesis I often use space and place interchangeably.

This thesis engages with contemporary feminist and poststructuralist understandings of the construction of identities and subjectivities to disturb, firstly; the way that nursing is positioned in a subordinate relation, to medicine, specifically in rural places/spaces, and secondly, to disturb conventional understandings of gender, work and rurality. The influence of poststructuralist thought is very obvious in cultural and feminist geography. With its attention to difference, multiple positions,

and fluid, non-unitary identities rather than grand narratives and totalising theory, critical poststructuralist ways of making sense of the world offer key tools for exploring the positioning of nurses in rural space. Through the lens of feminist poststructuralism, I also look at an innovative nursing initiative, the Family Health Nurse<sup>7</sup> in Scotland, promoted as one ‘answer’ to problems of recruitment and retention of rural general practitioners. The arguments presented in this thesis are based on fieldwork carried in New Zealand and the Western Isles in 2002, 2003 and 2004. The fieldwork consisted mainly of in-depth interviews with, in the case of New Zealand, rural and remote nurses, and in the case of the Western Isles, Family Health Nurses.

### **Limitations of the existing literature**

The complexity of the positioning of rural primary care nurses demands attention from several different, but overlapping, literatures. The literatures that are reviewed in this section are those relating to feminist geography; geographies of health; rurality, gender, identity and work.

#### Feminist geographies

Feminist geographers have produced an impressive body of literature surrounding work, both paid and unpaid (Hanson and Pratt 1995; Kobayashi 1994; McDowell and Pringle 1992; McDowell and Court 1994; McDowell 1997; Massey 1995). Perhaps most closely allied to the work that I carry out in this thesis is that of Bondi (2003, 2004, 2005). Bondi has both participated as a voluntary counsellor, and has written about the intersections between counselling as an occupation and pressures to

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<sup>7</sup> The Family Health Nurse is a role recently introduced by the World Health Organisation’s European Office, which attempts to provide a broad, generalist nursing role that is the first point of contact with the health care system.

professionalise. Paying attention to individual professions or occupational groups, as Bondi has done, is important in order to counter analyses that tend to homogenise ideas about gender and work.

Professional groups, by definition, have bodies of knowledge surrounding them that have led to their construction as professions. Therefore, while feminist inspired geographic work that addresses the ways that gendered identities are constructed at work is very useful in the course of thinking about rural professional work it is not specific enough to address the particular occupation of nursing. Nursing is a particular type of feminised work that has a body of literature by and about nurses and nursing that aids in the understanding of the specificity of nursing work. Understanding the specificity of nursing work is essential in the exploration of the ways that spatialised professional identities are differentially enacted, contested and constructed. The literatures arising from nursing, and addressing the ideological construction of the identity 'nurse' are dealt with at length later in chapter three. But the bulk of the literature within nursing has focused mainly on city hospital nursing (Allen 2001; Coombs 2005; Halford et al. 1997; Walby et al. 1994; Wicks 1998), although Thompson (2001, 2005) and MacLeod (1999) explore hospital nursing in smaller, more rural centres. When non-hospital based nurses have been investigated in New Zealand, the focus has been on high profile historical figures such as Christchurch's Nurse Maude and Mother Aubert, with contemporary studies being absent. This focus on hospitals has served to render less visible nurses who work in the community, in one way or another.

## Geographies of health

The literatures surrounding the geographies of medicine, health and health care have also been silent on the positioning of nursing in health care. The absence of literature about nursing from geographies of health is particularly interesting and serves to illustrate, and further perpetuate, the invisibility of nursing in health care generally and rural health care in particular. Although there has been significant attention paid to the provision of rural health care in general (Gesler 1992; Kearns and Joseph 1997; Mueller et al. 1999), health geographers have largely confined their analyses of health care practitioners to issues of physician distribution, recruitment and retention, and some attention has been paid to threats to medical autonomy (see Barnett 1991; Barnett et al. 1998; Cutchin 1997; Gordon et al. 1992).

There is a large literature about medical autonomy beyond geography that has mainly focussed on the relations between the medical profession and the state (see for example: Friedson 1977; Fougere 1993; Rappolt 1997; Light 1993; McKinlay and Arches 1985; McKinlay and Stoekle 1988; Moran and Wood 1993). There has been little corresponding attention to relations between nursing autonomy and the state, and this thesis addresses the issue of contest over autonomy between nurses, doctors and the state. It is important to note though, that the recognition of an instability about medical autonomy signifies a potential gap into which nursing might speak.

Located in a school of nursing, a geographer, Andrews (2002, 2003, 2004) provides an exception to the lack of attention to nursing. Andrews' arguments revolve around discussions of, both the lack of attention to nursing by geographers, and the lack of attention by nurses to issues of space and place, as well as the productive convergences that may be identified when geography and nursing recognise each other. Andrews' work is frequently published in nursing journals, which serves to take

it out of the mainstream reading of many geographers. My work in this thesis builds on this invitation to engage at the intersection between nursing, spaces and places.

Geographers have been foremost in commenting on processes and discourses of health care restructuring (see for example, Barnett 1999; Barnett and Barnett 1999, 2003; Cloutier-Fisher and Joseph 2000; Kearns 1991; Kearns and Joseph 1997; Moon and Brown 2000; Wiles 2002). Also well canvassed by geographers have been the compliances and resistances that have occurred at the rural level to processes of restructuring (Barnett and Barnett 2003; Eyre and Gauld 2003; Kearns 1998; Thompson 2005). But the only attention to nursing within these works has been Thompson (2005), whose focus was small-town nurses.

A number of studies have looked at the convergence of restructuring, nursing, and identity (Walby et al. 1994; Halford et al. 1997; Halford and Leonard 2003; Thompson 2005). These studies provide useful insights into the ways that organisations are powerful in “generating subjectivities and contributing to the production of individuals” but perhaps most importantly that individuals also exercise power as “they take on, reinterpret and/or challenge dominant organisational/restructuring strategies and discourses” (Halford 2003: 304). But again these literatures have focused on hospital nursing and the ways that professional identities are constructed and contested in close proximity to centres of decision-making. The ways that rural primary care nurses are located within the changes in primary health care are in some ways far more complex.

This thesis does not seek directly to add to debates about health sector restructuring. In many ways the nurses who participated in this study sit at the borders of a restructuring health sector, and perhaps always have done so. The climate of change in which nurses are enmeshed is due to wider philosophical shifts at an

international level about the importance of mobilising health care practitioner energy towards primary health care, rather than has been the case in the past, on tertiary or hospital care. This philosophical shift may stimulate forms of health sector restructuring, but is not driven by conventional notions of restructuring.

#### Rurality, gender, identity and work

Often the word rural is collapsed into whatever pertains to farming. This somewhat reductionist notion of being rural constitutes or renders invisible other ways of being in rural areas (see Cloke and Little 1997 for extended discussion of this point). Those authors who have addressed women and rural work have predominantly studied women involved in farm work (see for instance: Gasson 1980; Whatmore 1991), or on farm pluriactivity (see Gasson and Winter 1992 and Evans and Ilbery 1992, 1996). Work by Little et al. (1991) and Little (1997) has looked at all rural work including voluntary work, so moving beyond the focus on farm work. While the work of Little et al. (1991) gave an indication of the occupations women were employed in, in-depth analysis of individual occupations was not part of the research. Little (2002) has also highlighted the point that research on/with women, whose primary work role is not related to farming has been slow to appear. Whatmore et al. (1994) also attempt to expand the debate beyond the focus on farming work, but semi-professional and professional work has only received scant attention. Exceptions to this lack are the work of Sawyer and Munn (1998) and Robertson (2000). Sawyer and Munn's study of rural accountancy is largely descriptive, lacks any theoretical underpinning, and does not pay attention to gender. Mellow (2002), explored the meaning of family for rural clergy. Yarwood and Cozens (2004) investigate the policing of the countryside in rural Britain, explaining that the role of rural police is contested as is the nature of

the countryside. Police are caught “between accountability towards local people ... and the state’s demands for greater efficiency” (ibid: 152). Work carried out by Robertson (2000) on rural women teachers focused on identity, but not necessarily on professional identity. Perhaps the most closely allied research is that of Mellow (2005: 51) who argues that rural life “problematizes notions of profession” and that rural professionals are caught between trying to reconcile “their experience of rural society with the standards of professional work that emerge from urban settings”. While Mellow (2005) mentions nurses, she draws on research with rural hospital nurses, and this not in great depth. The specificity of primary care nursing in rural space thus, remains under-explored.

Although not all nurses are women, nursing is a feminised profession. Feminist geographers have begun to argue that femininities are constituted differently within particular types of spaces, such as work spaces, and that they in turn help to make those places what they are (McDowell 1997; Laurie et al. 1999: 12). The co-construction of gendered identities and professionalised rural work spaces is not a random, uncontrolled process, but rather a governed and governable one. While recent feminist geographic literature focuses on ‘new’ femininities (Laurie et al. 1999), it is debatable if the gendered professional identities that are the subject of this thesis are ‘new’ rather than perhaps rediscovered, or have gained a higher profile due to increasing attention to the regulation and auditing of health work and workers, as well as greater attention to rural health care. That is not to say that I think these identities are fixed in any way, but it would be to ignore the historical record, and the persons that made that historical record to construct these nursing identities as new. Although it may be the case that these professional identities have been re-discovered by those governing health care as potentially ‘useful’ in the provision of cheaper primary

health care. In many ways the traditionally formulated rural primary care nursing identity is a precursor to the newly developed role of ‘nurse practitioner’, which will be discussed further later, but for the purpose of introducing the theoretical framework adopted in the thesis it is important to provide a brief explanation of the new role.

The nurse practitioner (NP) role has been developed to be the most advanced clinical nursing role that can be achieved in New Zealand. The NP role is the most autonomous formal nursing role available and may include prescribing rights with the requisite training. The requirements for achieving the role are rigorous, costly and time consuming and it is a role that is tightly regulated by the New Zealand Nursing Council<sup>8</sup> and legislation. Rural primary care nurses’ work roles are very similar to the highly regulated NP role but their roles have been largely informal accretions of skills and training as these became available and nurses deemed them necessary to their practice, rather than requirements to practice. So in an ironic twist, what could be argued to be a rural inspired role of autonomous practice has been taken up, formalised, and regulated. That is not to say that the current rural primary care nursing roles are not regulated, but rather that they have been informally created and are regulated in an ad hoc fashion. Perhaps it is the case that when a role is to enter the mainstream rather than the periphery the ways that it challenges boundaries become more obvious, and in a health care climate governed by anxiety about public safety and fear of litigation, there is a perceived need for more overt controls. The rural primary care nursing role is simply so broad that it is extremely difficult to reduce to a list of requirements and competencies. None of the rural primary care nurses in this research have so far gained NP status although some of them are working towards

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<sup>8</sup> The official role of the New Zealand Nursing Council is as protector of the public safety, as is that of the New Zealand Medical Council.

this, so in the absence of this tightly controlled role, the question remains as to how nurses' practice is governed in the relative absence of tightly defined systems of regulation.

## **Theoretical Frameworks**

### Governmentality and the rural

The overarching theoretical framework of this thesis draws on the notion of governmentality following Foucault (1979). Dean (1999: 2) says that the “term *governmentality* seeks to distinguish the particular mentalities, arts and regimes of government and administration that have emerged since ‘early modern’ Europe”. Of particular concern here are those forms of contemporary rule that have coincided with the demise of the welfare state and the changing form of liberal government that has repositioned expertise and professional knowledges. Critiques advanced within neo-liberalism regarding the welfare model included the issues of cost and inequity, but also the way that discretionary authority was granted to “unaccountable professionals and administrators” and the “crushing of autonomy” (Rose 1993: 294). Within advanced liberalism these criticisms were responded to by mobilising a different way of governing expertise. I understand governmentality to be the conceptual point of intersection between technologies of power (rule by force) and technologies of the self (rule by consent). As Rose says:

‘Advanced liberal’ government entails the adoption of a range of devices that seek to recreate the distance between the decisions of formal political institutions and other social actors, and to act upon these actors in new ways, through shaping and utilizing their freedom (1993: 295).

Rose suggests three devices used in advanced liberal governance. These are firstly, “a new relation between expertise and politics” within which systems of trust in

professional credentials are replaced by such processes as contracting (budget disciplines), audit, and accountancy. The recently passed Health Practitioners Competency Assurance Act functions not as a replacement to trust in professional credentials but at least as an adjunct to it. Secondly, “a new pluralization of ‘social technologies’” operationalised through a ‘de-governmentalization of the state’ utilising instead a form of government that acts through shaping the “powers and wills of autonomous entities”, in this case professionals. The ways that rural primary care nurses engage in self management, or technologies of the self (Foucault 1988) to govern their own behaviour in ‘appropriate’ ways is an instance of this type of ‘social technology’. And finally, “a new specification of the subject of government” in which the powers of the consumer are enhanced and individual risk management privatised (Rose 1993: 295-296). For patients, the privatisation of risk management is evident in the ways that in the contemporary health care climate in which ‘faulty’ lifestyle is seen to be responsible for a great deal of ill health, the individual citizen is deemed increasingly responsible for their own health status and is encouraged to modify their lifestyle.

Foucauldian notions of governance and theories of governmentality have been widely utilised in relation to health care and health professionals (Goopy 1997; Minson 1997; Walker 1997; Driver 1994; Rose 1994; Osbourne 1993). But relatively little attention has been given by rural researchers to theorisations utilising governmentality, either as applied to or developed within the rural context (Woods and Goodwin 2003). Governmentality is an inherently spatialised concept with its sense of governance at a distance. Certainly there is scope for making this spatialisation overt rather than implicit and to investigate how at the margins of the contemporary state, gendered professional expertise is performed and governed.

Space is not merely a container for professional identity construction and relations. Rural professional (nursing) identities are constructed within rural space at the same time as they serve to construct that space as a particular type of health care surveillance space. The model of health care constructed from the convergence of profession and place has significant potential to expand beyond the rural in order to meet contemporary primary health care delivery goals. The question is whether the profession can practise in the way it does in the rural without being in the rural. How this question is answered has significant implications for enhanced understandings of the spatialisation of governmentality. Furthermore, issues of gender, power and language come to the fore.

#### Gender, power and language

One of the criticisms that has been levelled at poststructuralist understandings, of which governmentality is one, is that they are relativist arguments with little political utility (see Ramazanoğlu 1993; Edwards and Ribbens 1998). While acknowledging the criticism of relativism, I do not agree that poststructuralist understandings need necessarily be so and the use of feminist theories alongside poststructuralist ones can stimulate the re-politicisation of what may be potentially relativist theories. Thus, I hope to walk a tightrope between essentialising nurses as a group, victimising them anew, or taking a relativistic stance in which the experiences of these nurses is added to the melting pot of 'difference' and is thus devoid of any notion of political investment. In order to assist in thinking through this desire to maintain a political edge it is useful to use Foucault's understanding of the workings of power.

Foucault's concern with the mentalities of government needs to be set alongside the way that he conceived of power in order to grasp the significance of his

approach. Foucault reconceptualised power, its operation and its connections with knowledges and bodies, by arguing for an understanding of power in which it comes to be seen as not *belonging* to anyone in particular, as being *everywhere*, and as web-like rather than linear. Although not denying that some groups appear to wield more power than others in the social world, Foucault's thinking opened a conceptual space. This space allowed for a reassessment of the position of those who appear to be powerless, or at least less powerful in conventional terms. Traditional structural understandings, such as Marxism and early forms of feminism, may have advocated revolution or called for equality (usually within the terms of the established social order), but these forms of advocacy for change have had limited success. The durability of certain forms of inequity and gendering of identities were underestimated, which has demanded much more complex and varied ways of analysing the operations of power and the construction of gendered identities. These analyses have often drawn on the investigation of language.

Consistent with the commitment to poststructuralist theoretical frameworks, is the acknowledgement of the importance of discourse and language. One of the contributions of a poststructuralist approach has been to call into question the way that we think about language. The key argument advanced is that language does not reflect a pre-existing reality, but rather it mediates and constructs something we come to think of as reality (Foucault 1970, 1972; Weedon 1987). If we see language in this way, a kind of space is opened up, a window through which we can begin to look at the ways power works, how resistance operates, and the possibilities for change; as Weedon argues:

Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity, is *constructed*. The assumption that subjectivity is constructed implies that it is

not innate, not genetically determined, but socially produced. Subjectivity is produced in a whole range of discursive practices – economic, social and political – the meanings of which are a constant site of struggle over power (1987: 21).

Discourses can be understood as frameworks for understanding and communicating. Rather than letting words speak for themselves, the analysis of discourse treats texts as mediated cultural products that are part of wider systems of knowledge that may set the limits for, or discipline, everyday life. Discourses are not single, unitary products of individual authors but are broad sets of meanings and practices that are situated and embedded in particular contexts, societies and histories (Panelli 2004: 243). The specific use that is made of feminist and poststructuralist theoretical frameworks is addressed in each chapter so is not elaborated here. The epistemological framework is also further elaborated in chapter two. While the overriding ‘attitude’ with which I approach this thesis is feminist and poststructuralist, it is also important to note that the thesis is theoretically eclectic, since I have drawn on different theorists as their work informs the different parts of this thesis, but within the overall frame of governmentality. In sympathy with approaches to research drawing on grounded theory, this theoretical eclecticism maintains the contextual sensitivity, persuasiveness and relevance (Tolich and Davidson 1999) of the research.

### **Thesis structure**

The thesis is divided into three sections. The first examines the way that rural nursing is governed, while the second investigates the way that the rural nurse is self governing. The final section draws on these first two sections to make some practical policy-oriented conclusions, both about language/discourse and about how ‘rural’ practices might be fed back into the wider system.

Chapter two deals with the research process (epistemology, methodology and methods). This chapter begins with an exploration of the epistemological framework employed in this thesis in which knowledge claims are constructed, and it addresses the issue of the utility of critical poststructuralist analyses for instigating political change. Also addressed are the mechanics of the research including a discussion of the participants, an introduction to the Western Isles satellite study, and a comment on the research interview and data analysis. Ethical issues and a reflection on the research process, including my positionality conclude the chapter. The following two chapters, chapters three and four, together form the first section of the thesis. This section addresses the governing of the rural nurse. Chapter three provides a very necessary background to the ideological construction of the identity ‘nurse’ in predominantly historical terms. This attention to history enables an understanding of the genealogy of nursing, which in turn provides context for the professional identity of contemporary nursing. The ways that interprofessional boundaries between medicine and nursing were negotiated are explored. This chapter is essential in order to begin to understand the way that the nursing identity has developed in rural as well as urban areas, and the traces of gendered vocational commitment that carry through to contemporary nursing. This context aids in grasping the ways that nurses continue to be governed by notions of appropriate nursing behaviours in the construction of gendered professional identities and practices, imbued with gendered vocational ideology. Chapter four is the first chapter to engage directly with data constructed from in-depth interviews with rural primary care nurses. It investigates the ways that nurses are governed by means of formal discourses of law and risk. Systems of health care governance embodied in regulations surrounding nursing practice are seen to be stretched to points where individuals must take over and render practices ‘safe’.

The second section (chapters five and six) of the thesis is concerned with the ways that rural nurses are self-governing. Chapter five explores the ways that rural primary care nurses govern their own practice by negotiating and reworking role boundaries between medicine and nursing. Role boundary construction, maintenance and contestation take on a particular form in rural areas because of the temporal and spatial intensity of the rural primary care nursing role. Role boundaries between medicine and nursing are unusually fluid in rural places and nurses draw on discourses of holism in order to attempt to make sense of their boundary spanning roles. Utilising discourses of holism allows nurses to continue to situate themselves as nurses, rather than mini-doctors, an identity that they refuse, thus nurses govern themselves as nursing subjects rather than medical subjects even though they need to use the tools and practices of biomedicine episodically.

The sixth chapter explores a finer spatial scale than the previous chapters and examines the ways that nurses govern their own everyday practices. Drawing on the ways that rural primary care nurses are simultaneously mobile, in terms of moving to rural work, and confined within the practice of their work, this chapter deals specifically with the ways that nurses utilise techniques of self-governance to construct appropriate professional conduct. This appropriate professional conduct positions nurses as 'reliable' performers of primary health care work at the same time as it constructs the rural location as a particular type of space within which very high levels of surveillance both formal and informal are evident. Due to the highly visible and constant position of the nurse in the community both the nurse and the members of the community are constructed in ways that police the 'health' of both. The close proximity of nurses and patients presents a model of health care delivery that can at least potentially reduce fragmentation in care delivery and induce compliance with

lifestyle modification by the very presence of the nurse within the community. Nurses in rural primary health care show by the way that they manage practices of governmentality in the contemporary state that they can and do function appropriately as deliverers of comprehensive primary health care services, but as all three chapters show in various ways, the extended and expanded roles that they practise are poorly understood at many levels from the personal to the political. Although obviously problematic the placing of the nurse as the first point of contact, rather than the doctor as is the case at present in most urban healthcare, deserves further exploration.

The final section of the thesis investigates whether the rural primary care nursing role can be taken out of its rural context and continue to be a role designed to deliver comprehensive primary health care services beyond the rural. The two chapters in this section (chapters seven and eight) explore firstly, a satellite study of a site (the Western Isles) in which there has been an attempt to insert a generalist nursing role as the first point of contact to the health care system. The second chapter picks up on the way that generalist nursing roles in New Zealand and in the Western Isles are often looked on suspiciously and are poorly understood thus hindering the articulations of what the roles offer in place and hence what they have to offer beyond the places and spaces in which they are currently practised.

Chapter seven introduces a satellite study which explores the introduction of an intentionally constructed nursing role, the Family Health Nurse (FHN), which was created by the World Health Organisation's European Office specifically to attempt to address gaps in primary health care delivery. This role was intended to be a broad generalist nursing role and the nurse was to be the first point of contact to the health care system. The role was to have a strong focus on education and health promotion. This chapter investigates the difficulties that have been experienced in introducing the

role in the Western Isles, one of the pilot sites for its introduction. Where the nurse was initially intended to be the first point of contact in the health care system, in almost all cases this has not eventuated and the role remains poorly understood.

The eighth chapter explores the issue of contest and negotiation surrounding language. The awarenesses gained by conducting the critical analysis lead to a tentative conclusion that nurses may be able to play more of a role in rural places and they may be able to extend to urban places, but a language, a way of talking about what nursing contributes is needed in order to attempt to think how things might be otherwise. The final chapter of the thesis thus explores the issue of the development of this language and addresses the definition, ownership, and reception of language. Utilising psychoanalytic theory, the issue of how gendered and unequal speaking positions come to be constructed is explored. The credibility of any 'new' language, especially if it is a feminised one, is suspect. But tenuous gaps open firstly when paying attention to the ways that all, not just the feminine, are seen to be not in command of language. And secondly, when a socio-political climate of possibility is identified in which there is a potential gap for nurses to speak into in ways they have not been able to historically.

I argue that rather than a simple mapping on of a new language, nursing in general and rural nursing in particular is already engaged in constructing this language facilitated by a climate which is sympathetic to innovative ways of delivering primary health care and the contribution that nursing may be able to make. I conclude with ambivalent optimism, if such a thing is possible, for the insertion of a strategically utilised 'dialect' of nursing that is credible and convincing to those who oil the wheels of rural health policy in particular and primary health care policy in general. But that in order to take advantage of the gap that is opened in this analysis, nurses need to

recognise the gap and claim the space even though this claims making may involve speaking a kind of health care 'pidgin'.

## 2

# **The Research Process: Epistemology, methodology and methods**

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### **Introduction**

While I was engaged in researching rural primary care nursing, I was challenged on several occasions by nurses who were suspicious of the utility of a critical theoretical approach, such as that derived from poststructuralist and feminist theories, to the problematic of their positioning within rural health care provision. Some nurses were not convinced that critical approaches would ‘help’ nursing. Perhaps this suspicion is in part due to a misunderstanding of the focus of discourse work which, rather than being on individuals, is on the cultural frameworks of meaning that they reproduce (Burman 2004), and the difficulty in appreciating how understanding these frameworks could ‘help’ nursing. Obviously, definitions of utility and help could vary widely. My original intent was not to ‘help’, but rather to critically analyse, given that the intention of the research is to analyse what rural primary care nurses currently contribute to rural health care and how they make sense of their broad roles, as well as investigating what potential exists for the model of rural nursing to extend beyond the rural. But, not only does the challenge regarding critical analysis raise questions about conflicting notions of what and who research is for, it, in more general terms, raises questions about the utility of critical empirical/theoretical approaches in addressing social issues at all.

This chapter elaborates on the epistemological and methodological frameworks employed in the conduct of the research reported in this thesis, as well as discussing the particular methods that were utilised. The implications of applying epistemological frameworks drawn broadly from feminist post-structuralism are explored, paying attention to the consistency between the use of these particular epistemological frameworks and the methodological commitments that arise from them. The first section of this chapter discussing epistemological commitments, deals at some length with the potential of critical analyses to engender change by investigating the conditions under which knowledge claims are constructed and contested by analysing discourse. The second section of the chapter introduces the methods used and the participants included in the research. While this research is grounded predominantly in the New Zealand context, I conducted a satellite study in order to tease out the implications of extending the reach of generalist nursing work. To do this I explored the intentionally constructed role of the Family Health Nurse in the Western Isles of Scotland. I explain how that study fits within the thesis and the methods used in that study. The third section of the thesis deals specifically with the analysis of data and the research interview. I explore the research interview and what it can give access to. This section also includes a discussion of my positionality, acts of reflexivity, the workings of power and the role of ethics. In the final section in this chapter, I discuss the potentially problematic nature of the interview location.

The process of deconstruction carried out in critical analysis is often mistakenly assumed to lead to negation. The deconstruction of such categories as 'woman', the 'subject' and 'experience' which has been so much part of the post-structuralist effort has raised concerns. If the grounding of research cannot be situated within a positivist paradigm or by recourse to some transparent 'experience' of some

category called 'woman', the question that needs to be addressed is just where the ground for the knowledge claims resides. Furthermore, it has been argued that if all that remains is discourse, no 'real' things to hold on to any more (a form of nihilism), then how can there still be a political project, since to deconstruct something led to the conclusion that it must be rejected. Butler (1992) carefully argues that to deconstruct something is not to dismiss it, but rather deconstruction is an essential step in the process of freeing the above categories from their 'foundationalist weight' and opening them to re-signification. This for Butler, allows for permanent political contest which is the only precondition for politically engaged critique (Butler 1992). Rose (1993) goes further by suggesting that it is possible, and desirable, to simultaneously deconstruct and build up the category woman (in all its 'difference').

I am interested in this thesis to weave insights from theoretical frameworks located broadly within feminist post-structuralism and from the empirical world of rural and remote nursing. The outcome of critical analysis should least provide an enhanced understanding of rural nursing work which may indeed 'help' nursing and this goal is achieved by analysing the ways that knowledge is constructed and politically contested and the ways that knowledge-claims are legitimated within the construction of rural nursing.

### **Epistemological commitments: Ways of knowing**

In the preface to this thesis I indicated my early sensitisation to issues of power and gender in the construction and maintenance of professional identities. Contemporary feminist epistemologies, influenced by post-structural ways of thinking, make space for theorisations of power and gender that move beyond more simple structural (in the sense it is used in political economy) explanations that might, for instance, attribute

the subjugated status of nursing to a monolithic dominance of patriarchal structures. These structural explanations have tended to have too little explanatory power, particularly when addressing the enduring nature of forms of social interaction that are manifestly oppressive to some groups.

Post-structuralist analyses encourage more complex, deconstructive (Derrida 1967) investigations, that not only acknowledge the complexity of social life and social interaction, but also have more convincing explanatory power. They also open up the potential for change. As the workings of power and gender are opened up in the process of analysis, and greater understanding of how people themselves make sense of what they do is gained, there is the potential for demystification (Reinharz 1992) surrounding the workings of power and how gender is inflected in its working. Demystification can be seen as one of the first steps in the initiation of change, alongside the task of deconstructing the taken-for-granted, commonsensical understandings held about a given problematic. Challenging the commonsensical renders the present strange, and the 'natural' unnatural (Lupton 1995). That is not to say that I believe this thesis is the last word in the demystification of the co-dependent workings of power, gender and profession in rural healthcare, but it is to say that it represents one small part of that process of demystification, of beginning to think otherwise about what might have been, and what might be able to be, given different conditions. As Fairclough (2003: 202-203) says "[t]he aim of critical social research is better understanding of how societies work and produce both beneficial and detrimental effects, and of how the detrimental effects can be mitigated if not eliminated".

The production of knowledge is not a simple process but rather, it is one that raises many questions such as what counts as knowledge, who gets to produce it, and

under what conditions. In other words the production of knowledge is politically contested (Klein 1983; Stanley and Wise 1983; Harding, 1987, 1991; Reinharz 1992). One of the most compelling epistemological insights of feminism (along with other critical approaches) is the connection that it has made between knowledge and power (Lennon and Whitford 1994). This connection is not simply in the “obvious sense that access to knowledge enables empowerment; but more controversially through the recognition that legitimation of knowledge-claims is intimately tied to networks of domination and exclusion” (ibid 1994: 1). Both feminists and Foucault were thinking about the power/knowledge nexus concurrently (McNeill, 1993), and many feminists have drawn on Foucault’s in their analyses (see for instance, Fitzsimons 1994). Other feminists have been deeply critical of his lack of attention to feminist concerns and gender (Braidotti 1994; Ramazanoğlu 1993). In relation to the issue of power, while many feminists have drawn on Foucault’s work to think about the deployment of power, his conception of power as a web or net has the tendency to make the concept seem too diffuse, since it has no point of beginning, no source, and there is no-one powerful person able to be identified. We could, it seems, all share in power and its deployment equally. This conception of power does indeed have emancipatory potential, in that it expands the notion of power beyond a formulation that constructed power as the preserve of a few, but, many feminists argue that this version of power is not enough to help us think about the persistence of structural inequalities.

Notwithstanding these debates, Foucault’s work has utility in understanding the power/knowledge nexus. This nexus constituted an enduring theme in Foucault’s work on the human sciences. Foucault explains the connections between knowledge and power thus:

We should admit ... that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful);

that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (1977: 27).

Foucault (1972) used the notion of ‘discourse’ and the analysis of discourse to explore the terrain of power/knowledge. Foucault saw discourses as “identifiable collections of utterances governed by rules of construction and evaluation which determine within some thematic area what may be said, by whom, in what context, and with what effect” (Gordon 1994: xvi). Where ‘discourse’ had been associated with ‘language’, Foucault’s critical concept of ‘discourse’ moved away from this association and came to have more affinity with the notion of discipline, in both the scholarly and institutional senses of that term (McHoul and Grace 1993: 26). Foucault’s notion of discourse concerns the ways that knowledge comes to be produced, and to examine this he was interested in the “social, historical and political conditions under which, for example, statements come to count as true or false” at any given moment in time (ibid: 29).

Weedon (1987: 108) highlights the encompassing nature of the notion of discourse by indicating the way that discourses are more than simply ways of thinking and producing meaning, but are productive in the sense that they constitute the nature of that which they seek to govern. Sometimes it can seem as though people are trapped in hermetically sealed discourses. But discourse is not determinative in this way as is evident by the very fact that discourses can arise, mutate, and also disappear. In short, discourses are subject to change. Even though some discourses do have firm and apparently fixed institutional bases, these bases are also sites of contestation (Weedon 1987).

Paying attention to discourse means paying attention to how knowledge is produced through language. This task moves far beyond description, as Parker (1992:4-5) suggests, when he says that discourses bring phenomena in the social world into sight and categorise them, so providing “frameworks for debating the value of one way of talking about reality over other ways”. Furthermore, once an object has been brought into sight it is difficult “*not* to refer to it as if it were real” (ibid). Therefore, discourse can be seen as a “group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment” (Hall, 1992: 291. Cited in Hall, 2001). These ‘topics’ are relatively well-bounded areas of social knowledge (McHoul and Grace 1993) such as that of biomedicine.

The analysis of discourse, in the sense of the study of language in use and as social action, allows analysis of the ways that social actors are produced (Wetherell et al. 2001: 3). In this sense a discourse makes available a space for a particular type of self to step in, in that discourse hails us as a certain type of citizen. Understanding contemporary discourses that hail particular types of citizen as relativised or pluralised rather than unique and timeless ways of accessing truths about the social world leaves space for thinking about how things could be otherwise (McHoul and Grace 1993: 33). The process of exposing the historical specificity “of what we seem to know today with such certainty” also exposes the ways that “truth becomes a function of what *can be* said, written or thought” at any particular moment in time (ibid). For instance we ‘know’ with certainty that there is a ‘crisis’ in rural health care, for example, but as chapter three will demonstrate, there are political investments in that construction. The way that discourse is relativised or pluralized on analysis does not run counter to the possibility of a political project. As Foucault says;

“I am trying to define in what way, to what extent, to what level discourses, and particularly scientific discourses, can be objects of a political practice, and in what system of dependency they can be in relation to it (1978: 23, cited in McHoul and Grace 1993: 55).

Positions are generated for and by subjects (nurses) within discourse(s) via the workings of power and politics. Foucault, feminists (see Butler 1990, 1997; Grosz 1990; Laurie et al. 1999; Roseneil and Seymour 1999; Currie and Rothenberg 2001), cultural theorists and geographers (Keith and Pile 1993; Pile and Thrift 1995; Castells 1997) and others, are all concerned with the question of subjection and the political struggles associated with the construction of ‘identities’. As Lupton states:

[s]ubjectivity is produced both through the techniques of governmental self-formation produced by external authorities and agencies through the practices of ethical self-formation by which individuals come to know themselves and given [sic] meaning to their experiences. These processes are necessarily interrelated and reciprocal (1995: 303).

Understanding subjectivity as produced in this way resonates with the notion of ‘governmentality’ (Foucault 1979) that was discussed in the introductory chapter.

The production of knowledge about governed and governing rural professional subjects must be carried out with an awareness of the power dynamics involved. The potential for the model of rural primary care nursing to function beyond the rural is in no small measure related to the ability that nurses have to contest the conventional biomedical model as the only and best means of delivering primary health care. I investigate rural nursing in relation to the dominant discourse of biomedicine, against which nursing knowledge is subjugated. Foucault (1980) spoke of subjugated knowledges in two ways, firstly as blocs of historical knowledge disguised within the body of functionalist and systematising theory which are revealed by critical scholarship. Critical scholarship revealed the ruptural effects of conflict and struggle

that the order imposed by functionalist or systematising thought is supposed to conceal (Foucault 1980: 82). The second meaning involves the acknowledgement of “a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” (ibid). Interestingly, Foucault includes in the realm of these unqualified, or disqualified knowledges that of the psychiatric patient, the ill person, the nurse, the doctor, all of whom he considers to be parallel and marginal to the knowledge of medicine (ibid). These subjugated knowledges are popular knowledges. That is not to say that they are commonsense knowledges, but rather they involve a “particular, local, regional knowledge, a differential knowledge incapable of unanimity and which owes its force only to the harshness with which it is opposed by everything surrounding it” (Foucault 1980: 82). Foucault argues that it is through the reappearance of both of these types of subjugated knowledges that criticism does its work, since he sees these knowledges as being concerned with the historical knowledge of struggles which have been confined to the margins of knowledge (ibid: 82-83). To the union of the erudite or scholarly first form of knowledge and the local memories of the second, Foucault gave the name genealogy, which he says, “allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today” (ibid: 83). What the genealogical research activity does is to:

entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchise and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects (Foucault 1980: 83).

It must be stressed that Foucault’s task was not to dismantle science but rather, his concern was with exposing the political and strategic nature of forms of knowledge

previously thought to be relatively independent of power. He was concerned to challenge the conditions necessary for the production of scientific ‘truths’ (McHoul and Grace 1993: 58 -60).

I am interested in the everyday practices of rural and remote nurses and how analysis of these allow for an analysis of the workings of power. Foucault was convinced that power was best studied from the bottom up, rather than the top down.

Hence his insistence that one must:

conduct an *ascending* analysis of power, starting, that is, from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been - and continue to be – invested, colonised, utilised, involuted, transformed, displaced, extended etc. by ever more general mechanisms and by forms of global domination ... what must be shown is the manner in which they are invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies that are at once both relatively autonomous of power and act as its infinitesimal elements (Foucault 1980: 99. Emphasis in original).

For the purposes of this thesis and utilising Foucault’s injunction that an analysis of power should be an ascending one, I begin with the everyday practices of rural and remote primary care nurses. These everyday practices are analysed from in-depth interview material and two group interviews carried out with the same group of nurses who had recently taken on an emergency on-call role. Analysing in-depth the ways that nurses construct knowledgeable professional selves that span boundaries between biomedicine and nursing, nursing and paramedic work, and intraprofessional boundaries within nursing, promotes an understanding of space where tightly defined powerful discourses are stretched and reworked to construct appropriate local professional identities.

## **Methods**

### The participants

I made a very conscious decision to only interview nurses rather than patients, managers and doctors as well. This decision was very deliberate since I felt that because I was studying the professional identity of nurses it was they to whom I should be talking. I also felt that it may change what nurses said to me if they knew that I was interviewing managers, patients and doctors. The nurses who participated in the New Zealand component of this research are located predominantly in remote and rural areas of the South Island, and on several off-shore islands (see Figure 1.1). I interviewed a total of twenty-seven nurses; one nurse withdrew from the study. This number included all of the nurses who were the only health care provider in their area between 2002 and early 2004. There has since been some staff turnover. The nurses were all employed by either District Health Boards or Community Trusts. Sixteen of the nurses are in positions in which they are the only health care provider in the area for the majority of the time. Fourteen of the nurses provide twenty four hour emergency cover, as well as day to day health care, while seven of the remaining nurses provide after hours emergency cover on rosters, but not the bulk of the day to day health care. It is perhaps in the practice of the nurses who provide both day to day and after hours care that the most striking differences between rural and urban primary care nurses can be observed. But all of the nurses practise in ways that are different to urban nurses. It has become no more obvious over the course of this research why it is that the majority of the nurses providing first point of contact primary health care are located in the South Island of New Zealand and not the North.

The locations of nurses were gained by word of mouth and regional telephone directories, where contact details for rural clinics were, obviously, readily available. I made initial approaches by telephone, asking if the nurses were interested in participating and sending information sheets. I carried out in-depth interviews with the nurses in or near the places they worked. Interviews ranged in length from three quarters of an hour to three hours. These interviews were tape recorded and transcribed and the transcripts returned to participants who were free to alter anything they wished. Changes that the nurses made were mainly confined to deleting 'sensitive' information and correcting grammar.

As well as formal interviews, I attended the first conference of rural nurses held in New Zealand in 2001 (just prior to beginning the research in a formal sense). I also attended two further conferences where the rural nurses joined with the rural general practitioners. I treated these conferences as fieldwork, rather than seeing them as a site to present my work. I was interested to see what issues were uppermost for nurses in the first instance and also for doctors. I also wanted to observe the dynamics between nurses and doctors once the conferences came to be jointly held. I had the opportunity in 2003 to do two weeks of participant observation in one of the field sites and this significantly enhanced my understanding of the day-to-day-ness and comprehensiveness of the rural/remote nursing role. The main data generating form was the formal interview.

All of the nurses who participated in this study appeared to enjoy speaking about their work and needed very little prompting in most instances to do this. I have had on-going connections with quite a number of the nurses for unexpected reasons. Three quarters of the nurses involved in this research had completed postgraduate papers in nursing, with about a quarter of these being engaged in research papers,

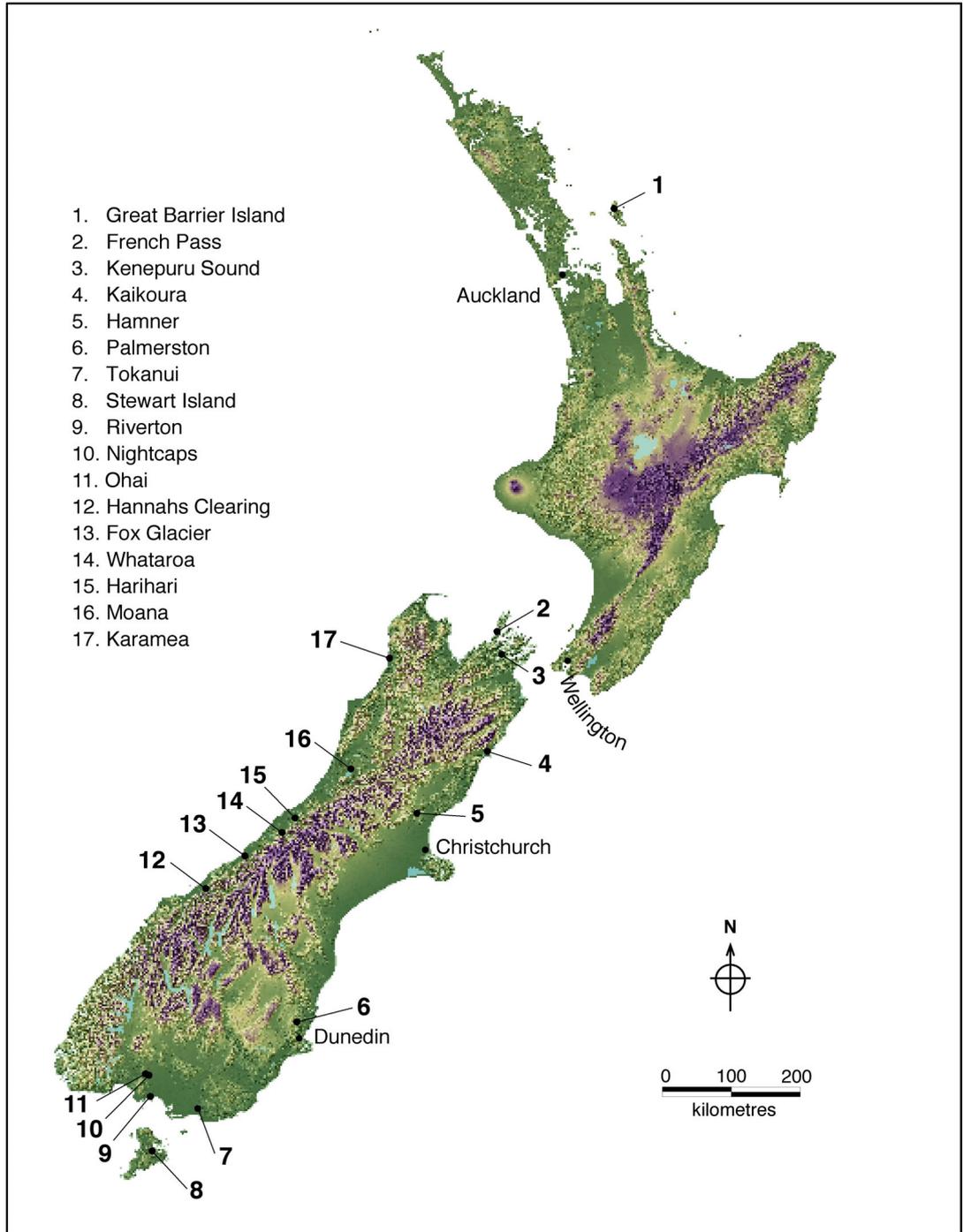


Figure 1.1

Locations of rural primary care nurses. Some areas have more than one nurse.

Cartography: Marney Brosnan



dissertation or thesis work, and have made contact with me to talk about their research and ask for help with literature. I have easy access to three academic libraries in the city, while none of these nurses have access to any in their localities. The ease with which I can access information, and the difficulty faced by rural nurses in doing this has been striking.

Conducting any research in New Zealand almost automatically presents potential problems with issues of confidentiality. New Zealand is a small country with a small population where issues of confidentiality are intensified. Via a long process of reflection on this I have made several decisions that I believe require explanation. Since I have researched a fairly small group of people who are mostly known to each other by extended and remote informal networks I have called all the participants “rural registered nurse”. Obviously this effort at anonymity is good for confidentiality, but at the same time it depersonalises and disembodies the participants. But I am not convinced that attaching pseudonyms to people, or having them choose their own, is any less depersonalising. I was anxious to make it hard to follow one pseudonym (hence one identity) through the text as I felt this may potentially identify participants. In all but one section I also wanted to mask the gender of the participants. There were four male nurses involved in this research and they would obviously have been readily identifiable if masculine pseudonyms were used for them. None of these decisions were made lightly and they became even more complex on reading Bondi (1997) where she argues for the importance of refusing to ‘neuter’ language as a strategy of resistance to the veiled masculinity of language. I am simply unsure of what the implications are of having chosen no pronoun at all and in many senses the masculine is already ‘other’ within nursing.

At the same time that I was conducting this research there was a New Zealand doctor who was also researching rural nursing. I made contact with this doctor and met him on several occasions at conferences. He was very concerned that I was 'stepping on his patch', and indicated this on several occasions. This was a view that I did not subscribe to and told him this, suggesting that the more research from different perspectives that was being done about rural nursing the better. But I found myself being very careful about what I said about my research when I was with him, since as he thought that I was 'stepping on his patch', I was concerned that he did not have any tools to undermine my research. Because my thesis takes a critical approach and I have had people misunderstand what that means and be very sceptical of the value of a critical approach to the study of nursing, I was concerned about the way that he might represent my research to the nurses that he interviewed (some of whom were the same as the nurses who participated in my study).

I was interviewing nurses at a time when there was some political tension surrounding the introduction of the new role of 'nurse practitioner' and it was this tension that led one of the participants to withdraw from this research. I was concerned that the withdrawal of this one nurse may lead to a snowball effect and I would lose more participants, but this was not the case.

#### Satellite study: The Western Isles

One of the questions that arises when examining the rural primary care nursing role is, why is it that these types of nurses are not employed elsewhere? And also, what is the potential for this generalist role to extend beyond the bounds of the rural? I was very fortunate to be able to push this line of questioning further and develop a satellite study in the Western Isles, where a World Health Organisation Pilot of a new

generalist nursing role, the Family Health Nurse (FHN), had recently concluded. This study is not intended to be directly comparative. Its scope is not sufficient to that task and furthermore the assumptions on which comparative studies are based can be highly problematic (see Gregor and Tuzin 2001). I am not comparing like units when I look at New Zealand and the Western Isles. Rather, I am taking the opportunity of investigating the conditions surrounding the development of the new role and its insertion into an already developed health care system, as well as paying attention to the everyday practices of the nurses who are interpellated (Althusser 1971) as a result of the creation of this new role.

In order to more fully understand the way that the FHN role had actually translated into clinical practice, I interviewed FHNs about their work. Although eleven European countries were involved in the pilot, the only location that had made significant progress was Scotland, thus it was the obvious general site to investigate. While four regions in the Highlands and Islands of Scotland were involved in the pilot project, for practical logistical reasons I needed to narrow down the geographical area that I could cover. The Western Isles, provided an ideal geographically defined space in which to locate this part of the research.

Having identified the nursing role that I wanted to investigate I attempted to make contacts through the Scottish Executive Family Health Nurse website, which contained the contact details for the pilot study's project officer. Having received no response from the project officer, despite a number of attempts, I had to make a decision about whether I should abandon my desire to study the FHN Role, or whether I should attempt to contact FHNs via other channels. After a very slow start I eventually met up with a FHN during the first of my two visits to the Western Isles and she became my key contact. I then sent a brief questionnaire for her to distribute

to the other Family Health Nurses in the Hebrides, the final question of which asked if they would be willing for me to come to speak with them personally about their FHN work. On the second visit, I interviewed seven nurses (of the eight) that are currently (in 2004) employed as FHNs in the Western Isles (see Figure 1.2). These interviews ranged in length from thirty minutes to an hour and a half. Interviews were transcribed and transcripts were returned to participants who were free to alter anything they wished. As well as the formal interviews, I spent a large amount of time, up to seven hours in one case, with the nurses and their facilitator, so I have a multitude of informal talk and also field notes written after these informal conversations.

On my second visit to the Western Isles a group meeting had been organised amongst some of the Family Health Nurses and their practice facilitator with me. I arrived at this meeting and it became obvious that the facilitator was a little anxious about what I might write about this new nursing role. She pointed out that it was a pilot project carried out under the auspices of the Scottish Executive. I came away with the impression that there was a degree of protectiveness about the role and the long term outcome of the pilot project, and not a little fear that she may have the power to stop my involvement with the nurses. There were a number of people who obviously have an investment in the continuation of the role, including the nurses, the people who constructed the training programme, and not least of all the funder: the Scottish Executive. The practice facilitator had been in contact with the FHN project officer in the Scottish Executive who had requested that she write a report of her meetings with me. We had one meeting of about one hour, and a more relaxed meeting/meal over about four hours on another occasion. I have agreed to keep this person informed of what I am doing and she is interested to see what is eventually

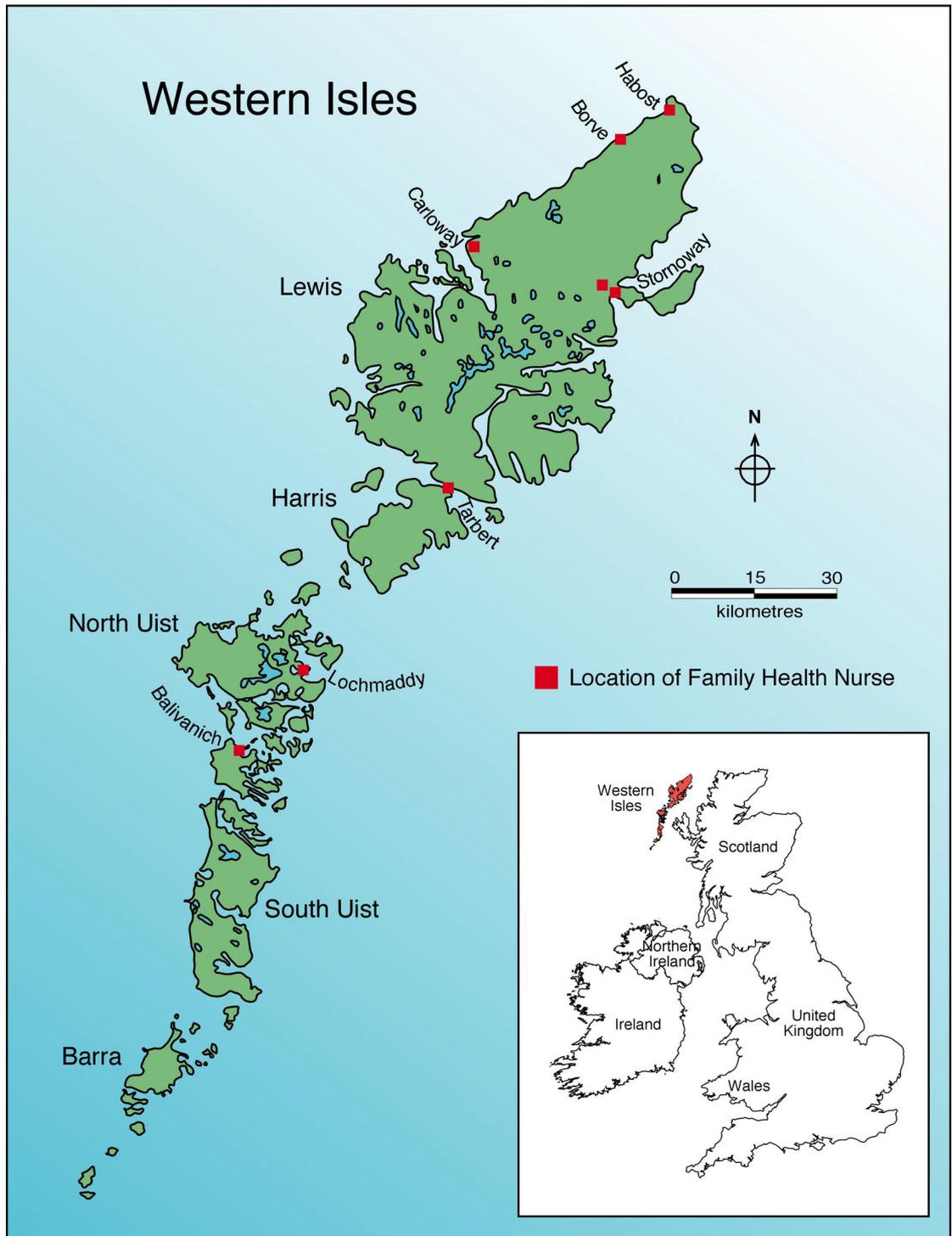


Figure 1.2

Locations of Family Health Nurses.

Cartography: Marney Brosnan



written about this section of the thesis, which she will pass on to the project officer in the Scottish Executive.

### **Analysing data, interviews, reflexivity and the negotiation of power relations**

The practice of interviewing is not a straightforward production of data which provides access to truths about any given problematic, but is more akin to a conversation, albeit a ‘conversation with a purpose’ (Cloke et al. 2004: 149). I want to critically examine the key data generating technique (method) that was used in this research. While I am convinced that in-depth interviewing has been the most appropriate method to address the questions that I was interested to explore in this thesis, it is not without problems. I want to expand on some of the issues surrounding the research interview, and what it can give access to.

Interviews have become a commonplace event in contemporary social life. Yet, Gubrium and Holstein, following Foucault, say that “the now self evident view that each of us has opinions of public significance became intelligible only within a discourse of individuality” (2002: 6). In what has been termed the ‘interview society’, national news programmes, Oprah Winfrey, market research companies seek to discover truths about individual experience in the event of the interview. It is assumed that straightforward information or facts are accessible to questioning.

Feminist postmodern epistemological commitments require that experience, as a ground for knowledge claims, be deconstructed. Scott, for example, suggests that any use that is made of ‘experience’ in which it is assumed to contain a transparent meaning “reproduces rather than contests given ideological systems” (1992: 25).

Scott would rather conceptualise experience, not as that which individuals have, but rather she would see that it is subjects who are constituted through experience (ibid 1992: 26). In Scott's approach, experience becomes not the ground of our argument but that which we seek to explain. Looking at experience in this way positions it as historically and spatially located and not as a means of access to truth and reality. Experience becomes that about which knowledge is produced and this process also historicises the identities it produces (Scott 1992: 26). The task thus becomes to explore the discursive operations by which identities are negotiated. This process is, inevitably, contested and therefore political.

The process of deconstruction leaves the research interview alive but highly contingent. Without making any claims to having access to truths of experience, research interviews are better seen as "politically situated and interested practices for producing and recontextualizing discourse..." (Briggs 2002: 916). I am attempting to make sense of nurses making sense of their working worlds. There are, hence many layers of meaning consisting of constructed stories and partially coherent narratives. Life in the social world is messy and I have no wish to tidy it up, but in "deconstructing the photographic meaning of representation, as a critique of objectivism begs, means taking greater caution over our representational claims and avoiding obscuring the perspectival nature of knowledge" (Alldred 1998: 162).

Within the epistemological framework elaborated above, language or text, in its many forms, comes to be seen not as a transparent reflector of pre-existing 'facts' or 'truths', but rather mediates or constructs meaning. Thus if the purpose is to attempt to analyse the workings of power, interview data do not give direct access to statements about how power works, but rather, give clues and hints as to the ways that

power is operating at a micro level These clues and hints allow for a building out from them to wider forms of meaning making i.e. knowledges and discourses.

These hints and clues do not jump off the page ready formed for analysis, but are identified as significant due to the positioning of the analyst (Butler 1992; Rose 1997; Mauthner and Doucett 1998; Ribbens and Edwards 1998). My focus, interest and theoretical grounding in feminist theory in terms of power and the construction of knowledge, nursing, and the crucial importance of incorporating the spatial, govern to a greater or lesser extent what will strike me as significant. That is not to say that I could choose anything to be significant. Paying attention to the corpus of data created as a result of interviews means paying attention to themes that are common, that begin to repeat over numbers of transcripts, but it also means being open to the unexpected. From this point I relied upon a reflective but dynamic movement between data, literatures and theories to come to the themes that have become the chapters in this thesis.

As already noted, poststructuralist accounts of the operation of power have made an analysis possible that moves beyond understanding power as simple oppression by one group of another. The move beyond structural explanations demands a different type of analytic questioning which goes far beyond attempting to identify which structures oppress which people. Rather the task is to find out how individuals insert themselves into particular discourses. In the case of this thesis the investigation concerns the ways that rural primary care nurses take up hybrid professional identities spanning the discourses of biomedicine and nursing and having done that, to investigate the discourses that nurses then continue to utilise to make sense of these hybrid professional identities that strain conventional urban definitions

of nursing identities. Particular types of subjectivity are called forth in rural primary care nursing, but they are also called forth in researchers.

Reflection on the research process: power, positionality and ethics

The commitment to feminist and poststructuralist epistemologies draws particular research performances from the researcher. What is appropriate behaviour in the context of research carried out within feminist paradigms has been the subject of vast numbers of publications and is continually debated, worked and reworked. Since the early 1990s, however, a type of consensus has emerged around the desirability of any given research process to be reflexive. Feminist theorists and researchers in particular, although not exclusively<sup>9</sup>, have lauded reflexivity as a core tenet of ‘good’ research.

It was out of the critique of positivist research’s claims to objectivity and the ‘God’s eye view’ (see Lloyd 1984; Haraway 1988; Nicholson 1990), that the concern for reflexive research grew. The claim that rather than there being any possibility of objectivity, all knowledge is seen to be located and all researchers are positioned somewhere, logically gave rise to the need to examine that positioning and to accept that since there is “no way to remove the effect of the researcher on what is researched, we need to introduce ways of making these effects explicit” (Tolich and Davidson 1999: 38-39). It was by examining this ‘positioning’ that feminist researchers, it was argued, could address preconceived ideas, exclusions, inclusions and prejudices as they/we carry out our research.

The technique of reflexivity in research centres, broadly speaking, on interrogating both theoretical positioning and social positioning (England 1994). The “reflexive turn” (Edwards and Ribbens 1998) has meant that researchers “must

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<sup>9</sup> For the sake of producing less clumsy writing I use the term ‘feminist researchers’ for the duration of this paper to cover all of those researchers who use reflexive methodologies.

continually confront questions of the nature and assumptions of the knowledge we are producing, and who we are producing it for” (Edwards and Ribbens 1998: 4). These arguments are by now well worn, to the extent that Crang suggests that “reflexivity has become something of a shibboleth – no one will brag about being unreflexive....” (2002: 651).

In an article published in 1997, Rose indicated ambivalence regarding reflexivity as a tactic in research. Most importantly Rose questioned the possibility of selves being fully knowable and transparent. This “transparent self then looks outward, to understand its place in the world, to chart its position in the arenas of knowledge production, to see its own place in the relations of power” (Rose 1997: 309). As Rose pointed out, neither of these understandings of reflexivity, a fully knowable self, or a fully knowable ‘other’, stand up to close analysis. That is not to say that reflexivity should be abandoned, but we need to be aware that it is always a partial, temporary awareness. Kobayashi (2003) also questions the utility of reflexivity in assisting researchers concerned with a social change agenda.

I want to shift the lens and look at the reflexive researcher as one who is located within the terrain of Foucauldian notions of governmentality, which raises questions about the nature of the reflexive subject. If governmentality is understood as the point of intersection between technologies of power (rule by force) and technologies of the self (Foucault 1988) (which induce consent), then by the concurrent working of institutional ethics committees (technologies of power), and the self-examination of the reflexive researcher (technologies of the self), the reflexive subject is interpellated. By this process we become self-governing researchers who behave, in the main, in orthodox and predictable ways. But in much the same way as notions of holism in nursing have been inflected with gender

connotations (Boschma 1997), reflexivity, which includes concerns about the ethics of representation and power relations, may have gendered implications. De Vault wonders if these reflexive commitments unwittingly perhaps, reflect a collusion “with ideological constructions of “woman” as especially moral or caring, or perhaps, a learned discomfort with authority that many women feel” (1999: 188). Of course, this is a circular argument, but nonetheless an important one to acknowledge, while not downplaying the continued importance of reflexivity in research.

### Negotiating power relations and interstitial positions

One of the key concerns of feminist research has been the need to address power relations between the researcher and the participants (Acker et al., 1991; Holland and Ramazanoğlu, 1994). While I did not have to negotiate radically uneven power relations in the conduct of this research, there were nevertheless, some issues around power that it is useful to explore and that are quite subtle. As an ex-nurse I sat in an awkward position within this research, being neither an insider, nor a complete outsider. The interstitial space in which I am located in relation to my (previous) profession is also evident in a reflection written from notes in my research journal:

I was sitting in my parents’ lounge talking to the district nurse who had come to attend to my father who has cancer and feeling totally confused about whether I was a researcher or a daughter. It is only when I came to write this up later that I realised that I had only briefly considered mobilising my previously dominant identity of nurse in this setting, and immediately dismissed it. Nurse = not daughter; for me at the time the contest was between identities as researcher or daughter. I wondered if it was appropriate to attempt to be both in this setting. I also wondered about the ethics of what I had fallen into.

My mother had told me about a month prior to my visit that the district nurses employed by the local health authority, but working out of their medical practice, were about to go on training courses in order to prepare them to share on-call work with the doctor. The three-doctor practice had recently lost two of the doctors.

My mother thought that she was being helpful when she suggested to the nurse, there to visit my father, that I might like to talk to her after she had attended to him. My mother effectively set up an interview for me. I seemed to have got myself to a point of no return. I did have a conversation with the nurse, asked her if she would be interested in being interviewed properly, and I said I would send her my information sheet. She offered to ask the others in the team if they were interested in participating in the research as well. All of this was happening with my father in bed in another room. I could not give full attention to the nurse and she could not give full attention to my father. I don't know if it bothered her or not. It bothered me, however.

I left wondering how appropriate it was to attempt to include nurses in my research who provided care for my parents, knowing that they would ask how the interviews went, who was there and bearing in mind the overriding concern with confidentiality I would be in an awkward position.

At a number of conferences when I called myself an ex-nurse, rural nurses would say 'once a nurse, always a nurse'. But, in the new climate of regulation, I will no longer be able to maintain a nursing practising certificate, since I am no longer engaged in clinical nursing. I either needed to engage in some clinical work in order to meet the requirements of the new Competence-Based Practising Certificates, or cease to claim a nursing identity. It is this latter path that I have chosen. Traditionally some clinical nurses have been suspicious of nurses who have gone into academia and have abandoned clinical nursing. These nurses often feel that academic nurses have lost touch with the 'reality' of clinical practice. It is this type of suspicion, I suspect, that led into nurses' challenging me about the utility of critical approaches to the analysis of nursing work. Nursing leader Jenny Carryer elaborates on the ambivalence that many nurses have towards further education:

I think the profession is deeply confused about education; simultaneously valuing and rejecting it. On the one hand there are those who passionately embrace advanced education, knowing that it richly explains and informs practice and guarantees increased quality and safety of service ... other sources who hold the view that advanced practice is derived from years spent in practice rather than any formal insertion of knowledge and process into that practice (cited in Adams 2003: 304)

I do not believe I will ever resolve the problem of my multiple, differently positioned identities which are in conflict in this particular instance of research. There will be no singular, transparent self available and I have to be content with dealing with the messiness of intersecting identities. Furthermore, I will never be able to uncover (as if there waiting to be found) the ways that my personal connections with one of their patients played a part in the selves that the nurses constructed in our subsequent focus group interview. I will not be likely to find out if this connection was a factor in their agreeing to be part of the research in the first place. They may have felt obliged to say yes purely because of the personal connection. I am not likely to ever know this and even if I did I wonder what difference it would make. In short, if I have chosen to ask these nurses to be part of the research project and they have agreed then we, all of us, live with the messiness of this interaction. Some sort of meaning (but not truth) gets made in this web of unknowability. Just being aware of these types of dilemmas in research does not necessarily make them any easier to deal with.

The above interaction with the nurses attending to my father and the need to work up a consent form while in the field while doing the Western Isles fieldwork (see below) highlight the on-goingness of ethics via reflection. I gained ethical approval for the New Zealand component of this research prior to the addition of the examination of the Family Health Nursing role in Scotland. In New Zealand we do not normally require ethical approval to speak to people in their capacity as professionals. For the New Zealand component of the research I sought ethical approval for my research because I wanted to use verbatim quotations from the participants and felt that this was an appropriate course to take. I had not initially

intended to use verbatim quotations from the Family Health Nurses, so did not feel that it was necessary to go back to the University Ethics Committee prior to carrying out the Western Isles research. During the second visit to the Western Isles I realised that it would be beneficial to use verbatim quotations. I wrote up a consent form while in the field, which explained this situation and asked the nurses' permission to use verbatim quotations; if they wanted copies of the transcripts of the interviews which they were free to change, add, or delete anything they wished, and finally, I asked if they wanted a copy of the part of the thesis that related to their contribution. Although not strictly following due process via the ethics committee, ethics is never finished at the point of approval by an ethics committee and must be constantly negotiated and rethought, before, during and after the research process. A further issue that has arisen when I reflected on the interview data was that of the effect of the interview location.

### **Interview locations**

Some geographers have reflected on the significance of the location of the interview (McDowell 1998; Parr 1998; Elwood and Martin 2000). In the process of conducting this research I became aware that I may have unwittingly influenced some of the responses that were generated in interviews. In a previous piece of research (Thompson 2001), looking at town hospital nurses and professional identity, all the nurses were interviewed outside of paid work time, and often in their homes. They chose the time and place of interview. I was interested in this previous research to address the relationship between the public (paid work) and the private (family), and so asked questions that might tease out the ways that public and private worlds interact.

The first piece of research created complex and multilayered narratives about home and paid work. I wondered if, as a feminist researcher, researching with, predominantly, women I might have overdetermined the impact of the home/paid work nexus in this earlier research. I may have assumed that women were more likely than men to engage in struggles over the, often, conflicting demands of home and paid work. The combination of specific questions and an interview that was often located in the participants' home may have contributed to this.

Bearing these factors in mind, with this current research on professional identity and rural nursing, I decided not to ask specific questions about the public/private nexus and just wait to see if the issues arose in the context of the open ended interview. Elwood and Martin state that:

the interview site itself produces “microgeographies” of spatial relations and meaning, where multiple scales of social relations intersect in the research interview. Careful observation and analysis of the people, activities, and interactions that constitute these spaces, of the choices that different participants make about interview sites and of participant's varying positions, roles, and identities in different sites can illustrate the social geographies of place (2000: 649).

Where hospital nurses are virtually impossible to interview in paid work time due to the intensive nature of their work, rural and remote nurses are almost in a position that the only time they can be interviewed is in paid work time given the extended time that many of them spend either physically at work or on-call. Hence, nearly all of the nurses in this current research were interviewed in paid work time. Interviewing the nurses in paid work time raises several issues. Firstly, the autonomy assumed by rural primary care nurses in that they can choose to be interviewed at work. Secondly, the site of the interview (in the workplace) may have overdetermined the ways that responses were constructed. McDowell (1998) found that some of her participants seemed reluctant to talk about their home lives in an interview conducted at their

workplaces (cited in Elwood and Martin 2000: 652). By not asking specific questions regarding the negotiation of public/private worlds, as well as interviewing nurses in their workplace (their choice) rather than their homes the interrelation between the public and private may have been underplayed by nurses. Although some nurses did talk about the interaction between paid work and home, perhaps more would have.

On the other hand the occupational roles of rural/remote nurses are large ones that extend beyond the confines of an eight-hour shift of work. The very taking on of these roles may also say a great deal about the position of professional identity in the nurses' repertoire of identities. Elwood and Martin say that "microgeographies of locations construct participants' power and expertise, meaning that different locations might situate participants differently in terms of their power in the research process and their sense of the contribution they might make to questions being asked" (2000: 654). Many of the nurses were keen to show me around their clinics. They showed me what equipment they had and how the clinic was set up, I gained a sense that this domain (microspace) was under their jurisdiction. Having jurisdiction over work space stands in stark contrast to the way that practice nurses, for example, are positioned in clinics that are under the jurisdiction of the doctor that owns the clinic, the nurse being an employee of the doctor. Nurses have not tended to control space in the same way that doctors have, in that only in rare circumstances have they owned or rented rooms to practise from. The importance of teasing out the influence that interview location might make on research is in the implications that this has for interpretation of interview data since:

Participants may consciously or unconsciously position themselves differently with respect to the multiple roles and identities that structure their experience of different places. These explicit and implicit presentations of self have important implications for interpreting interview material, as participants might offer different perspectives on questions being asked, depending on where the interview is conducted (Elwood and Martin 2000: 654).

One of the ways of mitigating this possible overdetermination would be either to ask specific questions about the public/private nexus, or to reinterview the nurses in other locations. Neither of these options were available to me in the context of this research.

Reflection on my own research process has highlighted the ongoing nature of the need for reflexivity in the research process. Reflexivity is crucial as a means of positioning the self within the research in such a way that the theoretical and personal commitments of the researcher become as transparent as possible, so aiding in the understanding of how decisions within research are made and particular analyses achieved. The ways that researchers govern their own research conduct is a technology of the self in the same way as the governance of rural nursing selves. Thus research becomes an enterprise whereby the researcher trained in a particular way can be relied upon to practise appropriately, although, of course, this process is never perfect since we can only be aware of some of the conditions under which we construct knowledge in the ways that we do.

### **Concluding Comments**

As well as discussing and participating in a reflection on research practice, this chapter has explained the utility of critical discourse analysis in gaining a more complex understanding of rural primary care nurses' professional identity construction. Beyond gaining a better understanding of how nurses construct and negotiate hybrid professional identities, this chapter has also investigated the potential for change that critical discourse analysis can engender by helping to locate the conditions under which certain ways of thinking and knowing come to be seen as enduring and timeless 'truths'. Investigating how these 'truths' come to be

constructed opens the way for thinking how things might be otherwise. In-depth analysis of nurses' narratives shows the ways that they cobble together self-governing, emplaced professional identities that stretch boundaries but still manage appropriate professional conduct. In order to explore the potential for change in terms of the model of rural nursing functioning beyond the rural, it is crucial to understand the ways that nurses manage these stretched professional boundaries. But first it is important to understand the place of nursing knowledges in the medical division of labour. Deconstructing the way that nursing knowledges come to be subjugated within the dominating presence of biomedical knowledges, by exploring their historical construction is the task of the next chapter. The next chapter explores the ideological construction of 'nurse' in order to provide the genealogical material with which the contemporary discourse analysis is in dialogue.



## **Governing the Rural Nurse**



## The ideological construction of ‘nurse’

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### Introduction

Nursing in New Zealand, as in other parts of the world, has in the last thirty or more years undergone some of its most radical changes. The push to professionalise nursing has given rise to a process of increasing credentialism. Nursing, once a training gained by apprenticeship in a hospital, has become a degree programme based in Polytechnics and Universities<sup>10</sup>. The role of the nurse in health care has evolved from one of subordination to medical personnel and knowledge, to a recognition, at least in theory, that health care happens with the co-operation of a team of people with a variety of skills and knowledges, of which nursing is a part. But, it would be hasty to suggest that the notion of hierarchy in health care is an historical artefact.

This chapter provides a necessary background to the ideological construction of the identity ‘nurse’, in predominantly historical terms. This chapter is essential in order to begin to understand the way that the nursing identity has developed in rural as well as urban areas, and the traces of gendered vocational commitment that carry through to contemporary nursing. This context aids in grasping the ways that nurses continue to be governed by notions of appropriate nursing behaviours that go far

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<sup>10</sup> There was an attempt to set up a university degree in nursing at the University of Otago in 1923. By 1925, lack of agreement over who should fund the nursing lecturers salaries, the Department of Health or the University, and more critically, a lack of commitment to the notion of higher education for nurses meant the programme was not pursued (Jacobs 2001: 42).

beyond a simple successful completion of tasks, and where the construction of gendered professional identities and practices are imbued with gendered vocational ideology.

In some sense the discussion in this chapter performs the function of a genealogy in Foucauldian terms (see also Gastaldo and Holmes 1999). Whereas a progressive history, according to Brown (1998: 37), tends to “promise a certain future” a “genealogy is deployed to *incite* possible futures” by denaturalising and questioning taken for granted trajectories. The first section of the chapter explores the way that nursing developed as an occupation, its sometimes tense relation to medicine, leading to interprofessional anxieties, and how emerging nursing identities were policed by means of extensive surveillance. Within early nursing the training of the character of the nurse was as important, or of more importance, than training in skills and techniques. The moulding of a certain type of identity where the nurse was to be sober, clean, virtuous, respectable, who knew her place in relation to medicine and medical men and was preferably middle class (a ‘better’ class of person), set in motion a particular type of gendered occupational identity modelled on the middle class Victorian patriarchal home. The way that nursing has developed as an occupation which is positioned in a subordinate relation to medicine has in turn influenced the way that nursing practice is rendered governable. Where doctors were autonomous father figures (using the model of the Victorian home), nurses were handmaidens whose inferior positioning needed to be safeguarded in order to protect the strict division of medical labour. To help ensure that the ‘right’ sort of women were the product of nursing training, nurses inhabited tightly controlled environments in both their on and off-duty time. Extensive direct surveillance was thought to be the most effective means of ensuring appropriate conduct.

The second section of the chapter discusses the issue of non-hospital nursing, and how the 'right' sort of women could continue to be guaranteed outside of the direct surveillance present in the hospital environment, and how these roles have evolved to the contemporary period. Where most nurses in the early years of the twentieth century worked in hospitals, gradually a need for nurses in the community was recognised. In rural areas particularly, in both New Zealand and Great Britain, with ongoing problems of recruitment and retention of general practitioners, in many instances nurses provided primary health care. In New Zealand both the Backblocks and Native Nursing schemes are discussed as specific initiatives designed to meet rural health care needs. When nurses in New Zealand first began to function outside of these tightly controlled environments, as was the case for the early rural nurses, concerns were raised about how nurses' characters could continue to be protected outside the hospital setting. It was argued by those responsible for nursing at the time that the nurses recruited to work in these rural areas needed to be of an extremely high standard. These nurses might be those who would see rural practice almost as missionary work. Appropriate behaviour and character were guaranteed not by direct surveillance, but rather relied upon systems of self-surveillance. This self-surveillance drew heavily on notions of vocation drawn from the nurses' training. When the Backblocks and Native Nursing schemes ceased in the early 1920s, less formal systems of rural primary health care delivery have continued to operate until the contemporary period, with much more recent moves to re-identify rural nursing practise as a discrete scope of practice. This re-formalisation has been due to several legislative changes that have required different scopes of nursing practice to be more tightly defined, which presents immediate problems for rural nursing since its scope escapes traditional bounds.

The third section deals relatively briefly with the trajectory that non-hospital nursing has followed in the United Kingdom in order to provide a context for the satellite study of the Western Isles. The fourth and final section deals specifically with the convergence of traditional notions of vocation with contemporary discussions of the so-called ‘conundrum of care’. If care is thought to be an inherent trait of women then it cannot also be considered a skill in the occupational sense. The professionalisation project in nursing does to some extent place ‘care’ in an ambivalent position, but nurses in practice utilise both care and skill. The continued lack of understanding, and difficulty in articulating what nursing contributes to health care beyond extremely simplified ideas contributes to anxieties about what nursing can and should be doing and so fuels the climate of risk that arises when nurses’ practice extends beyond what are considered usual boundaries.

The historical development of nursing is well documented in the literature (see; Abel-Smith 1960; Davies 1980; Maggs 1983, 1987; Rafferty et al. 1997), but it is important to review at least some of these developments in the context of this thesis. This historical context is crucial in gaining a rich understanding of the contemporary rural and remote nursing environment, in both the conceptual and material senses. An understanding of the ideological construction of ‘nurse’ historically also allows for a better understanding of the ways that contemporary nurses are positioned in relation to medicine and doctors, and this in turn aids the understanding of the ways contemporary nurses negotiate risk, mobility and interprofessional boundaries and are thus governed at a conceptual distance.

### **The development of nursing as an occupation: Creating formal nursing**

I begin with what some might argue is an arbitrary starting point, and that is with the changes in nursing that occurred in the latter part of the nineteenth century, after the Crimean War (1854-6) and concurrent with the rise of the hospital as an institution. There is some debate as to whether the rise in importance of the general nurse was due to the efforts of people such as Florence Nightingale and Mrs Bedford-Fenwick, or whether it was due to the expanding needs of hospitals for trained nurses (Maggs 1983). To a large extent, this uncertainty is not as important as the fact that there were fundamental changes in what we have come to call general nursing that began in the latter part of the nineteenth century, and much of this change has been tied to the efforts of Florence Nightingale.

While it is beyond the scope of this thesis to go into the life and times of Florence Nightingale in detail, it is important to note that in recent years the once 'heroic' historical record has become more critical. But Nightingale's efforts during the Crimean War have become the stuff of legend (the lady with the lamp). In response to English national outrage at the suffering of wounded troops in the Crimea, Nightingale, at the age of thirty two and having no systematic nursing training, offered to organise and lead nurses to 'the East' (Poovey 1988). Of the thirty eight nurses that Nightingale recruited, over half were from religious orders (ibid). On leaving the Crimea in 1856, Nightingale never nursed again. In fact Poovey notes that in spite of the concern that she was going to die in the Crimea in 1856 of fever, and:

despite numerous undiagnosable illnesses and an almost constant personal conviction that she was dying, Nightingale lived until 1910; she spent most of the fifty-four years after her return from the East lying on a couch in London, seeing almost no one, and issuing reams of directives and reports about

sanitary conditions in India, the reform of the War Office, and the organization of military and civilian hospitals and nursing (1988: 165).

Nightingale was often credited with things that she did not do, but the breadth of her involvement in matters beyond nursing, which was not her main or primary interest, has often been overlooked (ibid). Be that as it may, it is Nightingale's interest in, and influence on, nursing that is of interest in this thesis.

On return from the Crimea, £45,000 had been raised in recognition of Nightingale's efforts there. The council set up to administer the fund, which came to be known as the Nightingale Fund, "decided that the money should be used to 'establish a permanent institution for the training, sustenance and protection of nurses and to arrange their proper employment'" (Baly 1987: 34-5, citing Nightingale Fund Council minutes. Resolution 8 November 1855). While often couched in heroic terms, the setting up of this permanent institution for the training of nurses was, what Baly (1987) calls, a humble experiment and a compromise. Of more interest here though, was the type of woman that Nightingale envisaged 'should' be recruited to nursing. Her ideal hybrid was one with "the morality and spiritual devotion of religious orders, the education of the middle classes, combined with the hardiness of working class girls" (Baly 1987: 37). The school was set up at St Thomas's hospital in London, and attracted few 'suitable' recruits, although in the media the school was touted as a great success. It was perhaps this publicity that attracted a few better-educated recruits, while hospitals also began to feel the benefit of having probationary nurses providing cheap labour (Baly 1987). After these rather slow beginnings, those managing hospitals realised more and more the benefits to having probationer nurses attached to their establishments, but on the hospitals' terms. As Baly says:

[b]y the 1880s ... almost all hospitals had lady probationers who went forth to pioneer nurse training, not alas, always as sanitary missionaries to 'bring healthy habits and order to the lives of the poor' but to be acceptable assistants to

doctors in hospitals now catering for the middle class. The biddable, young, neatly uniformed probationer was an asset to hospitals appealing for new clients. She was an even greater asset if she paid for her training (1987: 43).

Poovey's interpretation of Nightingale's work highlights the way that she (Nightingale), by utilising a domestic ideal, inserted nursing into the field of health care as supportive and subordinate to medicine. This supportive positioning helped "enhance the reputation of an activity overwhelmingly dominated by women" because it constructed nursing as less threatening to the contemporary status quo than were other arenas that independent women were attempting to gain access to at the time, such as medicine itself (Poovey 1988: 166).

Just what nursing training should consist of was unclear, but with the growing concern of the middle classes with the threat of contagion, following the cholera epidemics of the 1840s, there was increased interest in sanitation (Poovey 1988: 174). The organism responsible for causing cholera is transmitted by contaminated food or water and has, historically been a disease of poverty. Part of Nightingale's project was to deploy "the [middle class] domestic ideal to support ... the expansion of state administrative control over the poor at home (Poovey 1988: 166). Clearly governing the poor at home could not be done by nurses who worked solely in hospitals.

The structure that developed in health care was closely modelled on the patriarchal structure of the Victorian middle class family. With Nightingale mobilising the ideal of Victorian middle-class mother, the " 'angel in the house', as nursing's feminine ideal" (Hallam 2000: 10). As well as the angel, Nightingale uses a "military image of authoritarian female power", the 'battleaxe', which "served an explicitly colonialist aim of reforming and recreating the home of the sick poor into a facsimile of the female, middle-class home" (ibid). In 1859 the:

Ladies Association for the Diffusion of Sanitary Knowledge (LADSK) was founded by evangelical middle-class women who saw it as their moral duty to visit the poor and teach them about the virtues of fresh air, good diet, clean clothes and houses and clean living. These [white<sup>11</sup>] middle – and upper-class women, in a manner that forecasts the development of the Health Visiting movement some fifty years later, visited the houses of the poor in an attempt to redeem working-class women from themselves (Hallam 2000: 16).

Poovey argues that “the Victorian ideal of submission and domesticity always contained an aggressive component. For Nightingale, the role of the nurse was not only to care for the sick, but to become a public agent of moral reform, and through this agency, ultimately to undermine the power of medical men (Poovey 1988: 191-2, cited in Hallam 2000: 10). But with the growing power of bio-medicine, nurses’ ability to undermine the power of medical men was limited. And in order to maintain some power and respect the differences between nursing and medicine were exaggerated, with nursing leaders arguing “for a distinct, separate and unequal place for women which was subordinate to medicine but controlled by themselves” (Gamarnikow 1978). The division constructed between medicine and nursing was not one of equals, but rather, as one doctor said:

Once the great principle is established that nurses must not usurp medical functions, their sphere of usefulness in relation to medical men is clear enough .... Nursing may be roughly defined as care of patients under medical control. Such care or treatment is subsidiary to diagnosis .... This definition of the status and function of nursing is only another way of laying down a proper division of labour .... This principle of the proper division of labour defines the relation of medical men to nurses (*Hospital*, 8 June 1912, pp. 251-2, cited in Gamarnikow 1978: 108).

### Interprofessional anxieties

Nurse training came to be, and remained firmly located in hospitals until over half way through the twentieth century. But, in spite of Poovey’s insistence that

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<sup>11</sup> Discussion of race and racism within nursing are beyond the scope of this thesis, but see Hagey et al. (2001) for a discussion of immigrant nurses experience of racism in the contemporary context. See also Ware (1992) for a discussion of the complex interweaving of femininity and racism in the notion of white woman as symbol of civilisation.

constructing nursing as 'supportive' to medicine assisted its acceptance, Maggs says that:

Since nurse training reflected medical training and the division between medicine and surgery, general nurses ought, therefore, to be nurses trained solely in the care of patients in general hospitals; however, as we shall see, general hospital nurses were taught a core curriculum which was to provide them with a range of skills across the nursing spectrum. The general trained nurse came, therefore, to resemble not so much the hospital consultant as the emerging general practitioner, who indeed saw the new nurse as a direct competitor (Maggs 1983: 2).

Concerns regarding the position of nurses in relation to doctors were played out overtly in the debates about nurse registration, a debate that lasted from 1888 until 1919 in the United Kingdom and dubbed the 'thirty years war' by Abel-Smith 1960 (Witz 1992: 128). Both nurses and doctors were located in the pro- and anti-registrationist camps. Both the pro- and anti-registrationists in the United Kingdom drew on similar notions of the relationship between nurses and doctors that consisted of the subordination of nursing to medicine. But they argued from different points of view; the pro-registrationists believing that if nurses were registered, more control could be exercised over the essential attributes of the nurse. For the pro-registrationists this meant nurses needed to have enough technical knowledge in order to carry out the instructions of the doctor and to be able to report accurately the symptoms of the patient between the doctor's visits (Gamarnikow 1978) but that the nurse represented little threat to the position of the doctor. The anti-registrationists, on the other hand believed that registration did in fact, challenge the position of medicine:

If registration were to pass it could lead nurses to consider themselves as belonging to what is called a 'Profession'. The tendency would be to think of themselves much more the Colleagues of doctors instead of simply carriers out of the orders of doctors; in fact they would be some pseudo-scientific person (Gamarnikow 1978: 102, citing Sydney Holland in 1903, chairman of the London Hospital. Capitalisation in original).

The organisational autonomy that registration gave nursing in 1919 in the United Kingdom and 1901 in New Zealand, despite doctors' fears, did mask the actual position of nursing which consisted of occupational dependence, subordination (Gamarnikow 1978: 105), and surveillance by doctors.

### Surveillance

While I noted before that one of the intended ideological functions of the nurse was her role as a sanitary reformer, which entailed high levels of surveillance and intervention in the lives of the poor, the nurse herself was also to be a subject of surveillance. One of the appeals of the institution of the hospital as a site for training young ladies in nursing was the opportunity it gave for control of nurses' behaviour both at work and at 'home'. Training in nursing was also training in 'character'. In common only with the armed forces, nurses in training were housed in nurses' homes attached to hospitals, and within these homes nurses behaviour was fairly strictly monitored. If as in Nightingale's eyes, the 'nurses' of the past were women "who were too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else" (cited in Poovey 1988: 174), reform and control were obvious needs. Nurses were to be given plenty to do, their numbers kept to a minimum, and they were not to be allowed to 'congregate' with the orderlies or each other for that matter since "associating the nurses in large dormitories tends to corrupt the good and make the bad worse" (cited in Poovey 1988: 182). Indeed, a newspaper clipping found by American registered nurse, Lois Turley (Turley 2005), in her mother's old bible provides a list of Nurses' Duties from 1887 (Figure. 2.1), given as a job description to hospital nurses, that support the tight controls on nurses' behaviour. The goal was always to have discipline in all its manifestations become "instinct and a second

nature” (ibid). In a reading that could be credited to Foucault (1988) and his notion of ‘technologies of the self’, Maggs suggests that self-control, contained in the idea of discipline, “could enable all the elements of authority over nursing to be directed from a distance; in any situation the nurse could be relied upon to behave because she had been trained to control herself along desired lines” (1983: 192-193). I now turn to the development of nursing outside of hospitals in New Zealand and the United Kingdom and begin to make particular reference to the historical developments in rural and remote nursing.

### Nurses’ Duties in 1887

In addition to caring for your 50 patients, each nurse will follow these regulations:

1. Daily sweep and mop the floors of your ward, dust the patient’s furniture and window sills.
2. Maintain an even temperature in your ward by bringing in a scuttle of coal for the day’s business.
3. Light is important to observe the patient’s condition. Therefore, each day fill kerosene lamps, clean chimneys and trim wicks. Wash the windows once a week.
4. The nurse’s notes are important in aiding the physician’s work. Make your pens carefully; you may whittle nibs to your individual taste.
5. Each nurse on day duty will report every day at 7a.m. and leave at 8p.m. except on the Sabbath on which day you will be off from 12 noon to 2 p.m.
6. Graduate nurses in good standing with the director of nurses will be given an evening off each week for courting purposes or two evenings a week if you go regularly to church.
7. Each nurse should lay aside from each pay day a goodly sum of her earnings for her benefits during her declining years so that she will not become a burden....
8. Any nurse who smokes, uses liquor in any form, gets her hair done at a beauty shop, or frequents dance halls will give the director of nurses good reason to suspect her worth, intentions and integrity.
9. The nurse who performs her labors and serves her patients and doctors without fault for five years will be given an increase of five cents a day, providing there are no hospital debts outstanding.

Fig. 2.1

Source: Turley (2005)

## **Non-hospital nursing in New Zealand**

In the last two decades of the nineteenth century training programmes for nurses were set up in the larger hospitals in New Zealand (Belgrave 1991). These programmes were modelled on the Nightingale training and were often administered by Nightingale trained nurses. The setting up of programmes and the passing of the Nurses Registration Act in 1901 hastened the split between trained and untrained nurses. New Zealand was the first country in the world to formally register nurses.

Wood argues that:

The need for registration was argued on the grounds of protecting the public and medical profession from charlatan nurses. Whatever the rights of this argument, the Act [Nurses Registration Act 1901] heralded a century of control, regulation and discipline of a rapidly expanding nursing workforce (2001: 6).

Trained nurses increasingly distanced themselves from domestic work that had been part of the role of untrained nurses. Nurses, who had not actually been under medical control and had worked in the community, now began to come under the umbrella of the, increasingly dominant, profession of medicine and medical men. Since this early split, and despite the continued presence of 'private nurses' employed directly by individual members of the public, nurses have increasingly functioned as employees of health authorities of one type or another. One group of nurses does, to some extent buck the trend to hospital dominance. The particular focus here is on nurses working in rural areas.

In 1909 and 1911, with the Backblocks and Native Nursing Schemes, and again in 1970, with the establishment of practice nursing as an occupation in response to a national shortage of rural doctors (Hounsell 1993: 2), nurses were identified as a

group who had the potential to assist in the improvement of primary health care services to rural and remote communities. The Practice Nurse Subsidy scheme was introduced alongside the occupation of practice nursing and was intended to help general practitioners employ nurses in private general practice. The scheme, which initially subsidised fifty percent of a nurse's salary, was extended to urban areas in 1974, with a hundred percent subsidy introduced in the same year (Working Party 1987: 2). The subsidy was reduced to seventy five percent of the nurse's salary in 1986 (ibid). Burgess indicates that "it was a scheme begun on the inspiration of the New Zealand Medical Association and the Department of Health, with very little thought given to the implications for the nursing profession or allowance made for consultation with the profession before it was implemented" (1984: 46). The aim was that nurses employed in this way would be able to perform some of the more routine medical tasks in the practice, thereby freeing doctors to carry out tasks that only they could do (Working Party 1987). It was not, at least initially, the intention that practice nurses would work fully autonomously. A distinction between rural and urban general practice has re-emerged with the advent of the rural ranking scale that provides extra money to doctors who practise more remotely. In many ways the Native and Backblocks Nursing Schemes are of more relevance for my purposes in this thesis, since the nurses employed under the Practice Nurse Subsidy Schemes worked in close proximity with doctors, whereas Native and Backblock nurses worked predominantly alone.

Towards the end of the nineteenth and into the twentieth century, concerns were raised about Māori depopulation and infectious diseases. Hester Maclean, Assistant Inspector of Hospitals in 1906, "envisaged a need for district nurses to 'preach and show by practical example the gospel of cleanliness and proper

sanitation” (Dow 1995: 83). Education in healthy living, for example, was thought to be essential in regard to the treatment and prevention of tuberculosis, but this emphasis on education “implied that sufferers were personally responsible for contracting the disease in the first place” (Bryder 1991: 126). The move towards compulsory notification of the disease to the health authorities was intended to not only identify new cases, but “also to facilitate entry into people’s homes by sanitary inspectors and district nurses who were ‘to give general advice as to the life to be lived’” (ibid: 127).

Apart from the Nurse Maud District Nursing Service in Christchurch, in other urban areas the St Johns Ambulance Association sponsored their first district nurse in 1906 and more followed. For rural areas, Dr Valentine<sup>12</sup>, who was both Inspector-General of Hospitals and Chief Health Officer from 1909, argued that what was needed was a more equitable distribution of health services:

What we want is a hospital and charitable aid system that will make itself felt in all parts of these Islands – not only, as is the case at present, in the districts immediately surrounding the towns, but also in the far remote country districts – the backblocks...(AJHR, 1908, H-22A: 13).

To this end Valentine envisaged a district nursing service that would bridge the gap between the base hospital and the remote country districts (McKegg 1991: 111). The success of the Nurse Maude District Nursing service, set up in Christchurch in 1896, and the extramural services of the Plunket Society founded in 1907, both paved the way for a ‘Backblocks’ district nursing service in 1909 (Board of Health Committee on Nursing Services 1974: 13). An act of parliament was required to make this possible, as previously there had been no compulsion to provide services outside

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<sup>12</sup>Valentine had been a rural doctor and this may have made him more interested in rural health care in a way that his predecessors were not.

hospitals. In 1909 with the Hospitals and Charitable Institutions Act (enacted in 1885), local health boards were given the power to “use funds for nurses to care for the sick outside their own institutions” (Burgess 1984: 16). Two years later, in 1911, the Department of Health administered a ‘native nursing service’. These nursing roles were partially funded by the local Hospital Board, and partially by the local community.

Māori leaders such as Apirana Ngata, Peter Buck and Maui Pomare all believed that the “survival of the Māori people depended on their adopting a Pākehā lifestyle and Western medical practices” (Coney 1993: 92). The Māori Health Nursing Scheme was set up in order to attempt to address the appalling health status and population decline of Māori. Interestingly, Sir George Grey commissioned a report from Florence Nightingale in 1860 which was intended to address the issue of Māori depopulation. In ‘Note on the New Zealand Depopulation Question’, Nightingale stated that the diseases from which Māori suffered could be remedied by improving diet, clothing and accommodation. Nightingale also insisted on the need for education. The report was never acted on. Instead, recommendations from Dr Arthur Thomson were instituted. These were that the Government teach Māori Christianity and English, individualise property, build roads and English settlements, make the Queen’s law the law of the land, prevent disease, and promote intermarriage (Booth 1995: 7, citing Keith 1991).

The role of these ‘native nurses’ was to “provide advice for Maori women on feeding and care of their children, offer advice to pregnant women and if possible attend them at delivery, and undertake health education in regard to hygiene, nursing sick children and food preparation” (AJHR., 1911, H-31; page 183). The introduction of the Native Nursing Service in 1911 was well before the movement of large

numbers of Māori into urban areas. Thus, 'native health nurses' worked in rural locales, usually fairly autonomously. McKegg indicates that part of the agenda of nurses in these roles was to act as agents of change on behalf of government; to go into people's homes and aim to 'correct' behaviour:

This was particularly so for those district nurses sent into Maori communities. While part of the impetus for the establishment of the scheme was the concern for the appalling health status of the Maori people, underlying this was the added desire to remove the threat that contagious diseases in Maori communities posed to their European neighbours (1991: 3-4).

In this sense then nurses were to be agents of assimilation (McKegg 1991; Bryder 1991). But, Akenehi Hei, the first Native nurse in the government scheme, said that local customs "having kept the Maori race in vigorous health for many generations, deserve consideration .... A greater knowledge of the native mind will inspire a greater, and thereby a deeper sympathy for the Maori people" (Cited in Coney 1993: 93). Although initially staffed by small numbers of Māori women, positions in the Native Health Service, due to obstacles such as the lack of willingness on the part of hospitals to train them, gradually came to be held by Pākehā nurses (McKegg 1992). Coney says that the Pākehā nurses that were most successful in these roles were those who "became part of the local community and took the trouble to learn Maori ways" (1993: 93).

The number of nurses who worked in the Backblocks Nursing Service and the Native Health Service gradually increased as remote regions, especially in the North Island, called for nurses to serve their communities (Wood 2001). But, by 1913 there were only nine district nurses employed by boards in rural districts (Burgess 1984: 16). Of the women who took up positions as Backblocks district nurses and Native health nurses, many did not stay for more than two years. Of those that did remain in their jobs for five years or more it must be acknowledged that these women were

unusual in terms of both what was commonly expected of women and nurses. McKegg notes that, “while participating in an activity suitably ‘womanly’, backblock’s district nursing required much skill, a spirit of independence and large amounts of initiative. In the communities in which they worked they held positions of responsibility” (1991: 190-191).

As well as acute nursing of fevers and accidents, nurses provided health education to rural communities (Wood 2001). But, the narrow (hospital) training of early Backblocks nurses often left them often ill prepared for the breadth of the health care services that they provided (Board of Health Committee on Nursing Services 1974). “By virtue of their professional and geographic isolation some rural district nurses in particular exercised a high degree of responsibility and authority, their work often overlapping with that of urban doctors and dentists” (ibid: 14). Although regarded warily by some doctors concerned with preserving fees, these nurses generally maintained collegial relations with local medical men, with nurses having telephone contact with doctors and doctors in turn relying on nurses’ expertise (Wood 2001: 7).

The ‘right sort of women’ ?

The role of district nurse has long been acknowledged to be a relatively independent one, requiring independent judgement and autonomy without the immediate presence of supervisors, medical or nursing (Reverby 1987). In the United States, somewhat ironically:

at a time when public-health medicine was increasingly seen as a backwater of the medical profession, public-health nurses, because their practice involved autonomy from medical and hospital control and the provision of cross-class care and education, were perceived as the elite in nursing (Reverby 1987: 110).

In New Zealand, Valintine stated in 1908 that district nursing was a job suited to those “who wanted to play a particularly independent and devoted part” (McKegg 1991: 148, citing Valintine in *Kai Tiaki* Vol 1 no. 4 (October 1908: 112)). According to Dr Valintine, these nurses needed to be “women of rare character, devoted to duty and undaunted by hardship” (McKegg 1991: 127, citing AJHR, 1909, H-22: 6. ), with their work being “noble, unselfish and Christian-like as a missionary posting to heathen lands” (McKegg 1991: 127, citing *Kai Tiaki*, 1909 Vol. II (1): 4). McKegg goes on to cite Hester Maclean, Assistant Inspector of Hospitals, who described the job as being “for women who prefer the independence of working under public bodies for the poorer members of the community, rather than doing private nursing in the houses of the rich” (McKegg 1991: 148, citing *Kai Tiaki* 1910, Vol 111 (4): 137).

The nurses chosen for these outlying nursing positions were to be chosen for their ‘superior social station’, which was seen to be of more importance for the nurse who worked in the community “for she worked without the discipline and support available in the hospital” (McKegg 1991: 24. See also Reverby 1987). Maclean “declared that women needed to be discreet and of ‘high character and good training and experience’” (AJHR 1910 H-22: 10. Cited in McKegg 1991: 30). Ideally these early backblocks nurses were to have both general nursing and midwifery training but it was not always possible to recruit nurses who were also midwives. Apparently it was hard to find the ‘right type of woman’ with the necessary qualifications (McKegg 1991: 127). While there is no doubt that some of the women were attracted to the ideal of self-sacrifice, district nursing provided the nurse with an independence unable to be achieved working in the hospital. It also offered the opportunity of travel and the excitement of the unknown. In a fascinating re-telling of a story, Nurse Margaret

McNabb said that on the same day in 1933 she was offered two jobs, one as Plunket nurse in Timaru, and the other as a rural district nurse in Te Kaha:

I didn't know where Te Kaha was and asked at the Post Office if they knew where it was. They had never heard of Te Kaha either. They asked everybody who came in if they knew where Te Kaha was but nobody had heard of it. Finally one chappie came in and he looked at me and he said, "Te Kaha, ooh, that's a terrible place. There're still all cannibals there, you know ... I thought that Timaru sounded much too dull after that description so I decided to go to Te Kaha and the cannibals. I went to Te Kaha on the East Coast in 1933 (cited in Cowan 1998: 50-51).

Another rural district nurse, Myra McCormick originally wanted to be a chemist. However, living in Taihape (a small town in the centre of the North Island of New Zealand), there were no opportunities for such a training. She stated: "I couldn't see any future for me in running a house or bringing up a family. That sort of work I wasn't interested in ... All the girls around me were getting married" (McKegg 1991: 150-151).

During World War One, with the shortage of medical practitioners, many hospital boards made attempts to employ district nurses, and those who became district nurses found that their scope of practice widened as they took on tasks more commonly done by doctors (McKegg 1991: 133). In the wake of the First World War and the 1918 influenza epidemic, health became a prime concern of social policy, in which the Health Department "vigorously promoted links between personal well-being and national efficiency" (Tennant 1991: 131), with some blaming the high rate of rejection (nearly 60%) among First World War volunteers on an earlier lack of attention to child health (Coney 1993; Tennant 1991). Similar arguments about high rejection rates for military recruits were made in the United States, but Reverby (1987) argues that the high rejection rates may have also reflected increased expectations of what a healthy recruit might be. It was noted that recruits from rural

areas appeared to have poorer health and this point led to an increased interest in health care provision in rural areas (ibid). Similar sentiments were evident in New Zealand where one of the key ways to improve the health and fitness of the nation was seen to lie in rendering women more fit for maternity. It was recognised that:

the safety of nations is not a question of the gun alone, but also of the man behind the gun, and he is mainly the resultant of the grit and self-sacrifice of his mother. If we lack noble mothers we lack the first element of racial success and national greatness (Coney 1993: 66, citing Truby King 1925: 149).

This overtly eugenic ideology, at a time when eugenics was seen to be a “precise science which drew on modern research in demography, genetics, human biology and anthropology” lost credibility following World War Two when the implications of simplistic theories about racial purity that came out of the Nazi regime became obvious (Coney 1993: 71). Nurses were to play a key role in transmitting sanitary knowledge to the community when it was realised that preventative health education could be effective in improving the health standards in general. In 1922 Hester Maclean announced that the Backblock district nursing scheme for Europeans was at a standstill, although the following year saw a gradual increase in the number of district nurses appointed (McKegg 1991: 136). From the 1920s onwards the sharp distinction between the Backblock district nursing services and the Māori health nurses became blurred.

As well as the nurses employed in the Native Health and Backblocks Nursing schemes, there were also nurses located in remote areas of New Zealand with Public Works Department programmes in the early years of the twentieth century. With the discovery and exploitation of gold, coal and timber on the West Coast of the South Island alternative access to markets became imperative due to the relatively poor harbour access on the Coast (Rattray 1961:51). With the building of, what was then

known as the Arthur's Pass Tunnel, a cottage hospital was set up at Otira in 1911, staffed by one nurse until 1918 when another nurse arrived. The closest doctor was at Hokitika and contact with him was by an erratic telephone line (ibid: 52). Other nurses were located in South Westland with the Public Works Department at Paringa and also at Milford Sound where in 1936, Ethel Turner tramped the Milford Track and set up a "crude, two-bed ward with a detached tent as a bathroom. Sister Turner remained with the camp for five years" (ibid: 53). There has also been a nurse on Stewart Island since 1909 as Dr Valintine thought that Stewart Island would be a good place to "give the district nurse scheme a fair trial" (Swain 1970: 24). There were nurses other than those who worked for the Public Works Department who were located on the West Coast in the early part of the twentieth century and the work of some of these nurses is documented in Hawker et al. (1959). Although these nurses were the precursors to what we now know as industrial health nurses, at this early stage, their work bore striking similarities with the roles that nurses carry out in rural New Zealand today. Issues of isolation require far more than is generally expected of the urban nurse in terms of the scope of their responsibilities.

Isolation has been a fact of life for rural nurses with the West Coast area of the South Island of New Zealand presenting specific forms of isolation. Divided from the remainder of the South Island by the Southern Alps, providing road access to the West Coast and then down its length was both difficult and expensive due to the rugged nature of the landscape, and the very high rainfall. Figure. 2.2 shows the relatively late road access down the length of, particularly South Westland, including the Haast Pass. Although we often perceive of air ambulance evacuation as a contemporary phenomenon, prior to the completion of the Fox-Paringa-Haast road an air service, that functioned when necessary as an air ambulance, operated from the

1930s until the opening of the road in the 1960s (Waugh 1995: 68). A recently published book (King-Turner 2004) documents life as a district nurse in the Marlborough sounds (see Figure 2.2), including D'Urville Island. Based at French Pass, from 1948 until 1954, King-Turner saw most of her patients by boat or on foot, and patients were often evacuated by boat.

Historically, in rural areas in New Zealand doctors have been concerned that nurses would affect the profitability of their practices. McKegg notes that this was the case both in Britain and New Zealand. Valentine was at pains to point out that “in no sense of the word would the district nurse be expected to ... in any way take the place of the general medical practitioner” (AJHR 1909, H-22: 6). By 1911 Valentine was to say:

The success of the district nurse in this country is assured – especially where the medical men of the district are in sympathy with the movement, which is sure to be the case, provided the district nurse adheres to the rules laid down, and does not attempt to usurp the functions of the medical practitioner (AJHR 1911, H-31: 8).

In some cases the doctors were concerned that the nurses were keeping the patients in too good a health for their practices and were diagnosing and treating things that the doctors thought should be under their care (McKegg 1991: 37-38).

Threat to the independence of medicine came from other quarters and the advent of a social security system for New Zealand in the 1930s stimulated contestation surrounding the provision of general practitioner services, previously based on complete fee-for-service (Wright-St Clair 1989: 23). After much struggle and debate a fixed benefit, the GMS (General Medical Services) benefit, was agreed on by general practitioners and government, which gave doctors a government-guaranteed income. Doctors remained free to charge a fee in addition to the GMS, although many found that the GMS was sufficient. District nurses, who were

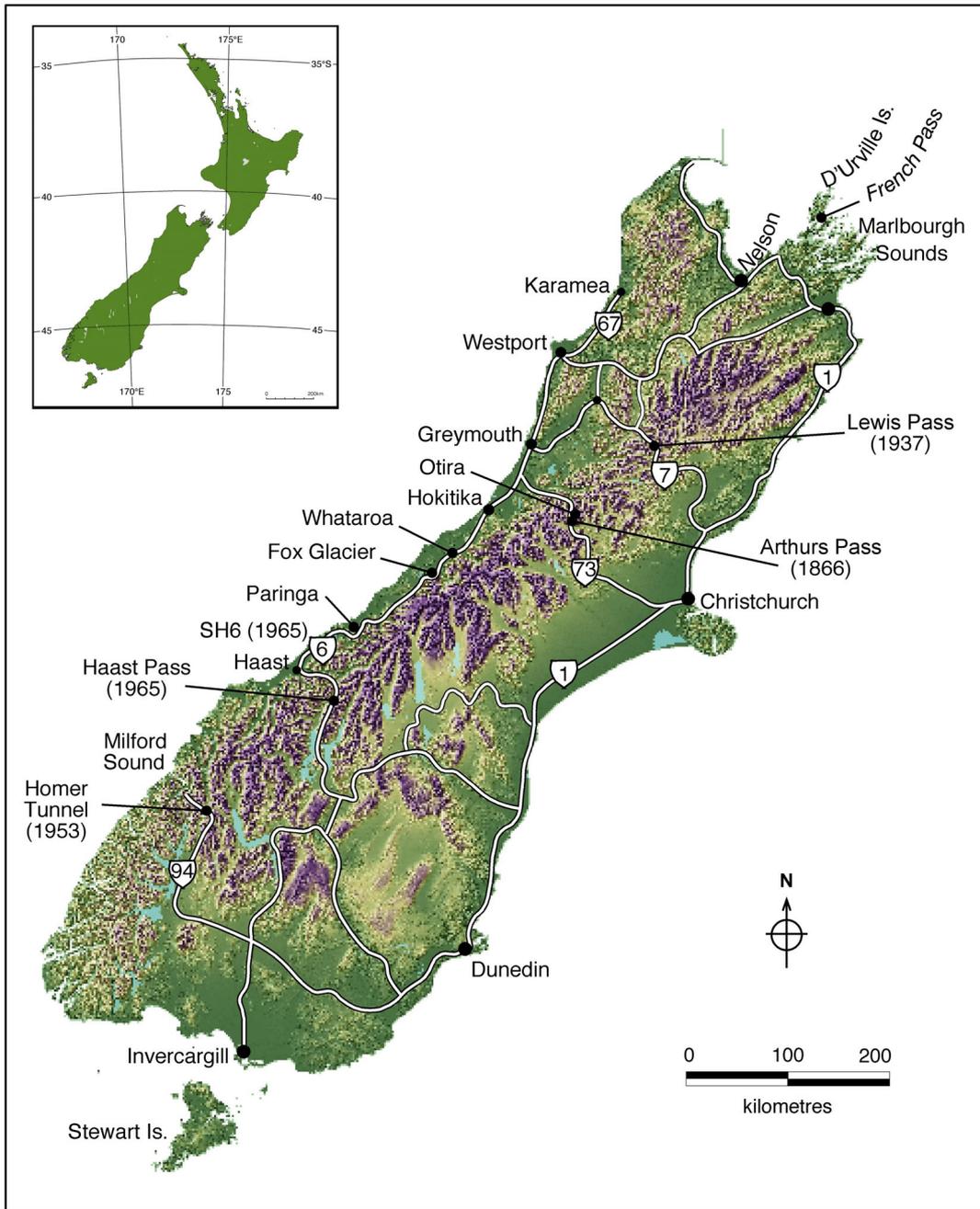


Figure 2.2

Opening dates of roads and mountain passes.

Cartography: Marney Brosnan



employees of Health Boards were supposed to charge a fee, but often did not as they had the discretionary power to decide who was able to pay (McKegg 1991). As employees, district nurses' incomes did not rely on fee-for-service in the way that the incomes of general practitioners came to in later years.

Over time the role of the district nurse shifted with changing emphases in health care and the focus came to be more on public health measures, for which the nurses were not always well equipped. District nurses were also working under a wide range of public and private organisations but gradually all came under the umbrella of the Health Department and in 1944, reflecting the advent of the 1938 Social Security Act, the District Nursing Benefit was introduced. This move encouraged hospital boards to expand their services, and since the financial status of patients ceased to be an issue district nursing services became free for all (McKegg 1991: 145).

Re-identifying a discrete rural nursing identity: The contemporary period

It is not since the demise (early 1920s) of the Backblocks and Native nursing schemes that nurses have had a defined rural nursing role as distinct from the more generic 'district nurse'. Contemporary rural and remote nurses, who are called by different titles depending on where they work, function in a different socio-political, cultural, and professional climate to that which their predecessors encountered. While nurses have continued to carry out nursing roles in rural and remote areas, it is perhaps only in the last ten years that there has been a growing desire to re-identify a discrete rural nursing identity. This move in itself is interesting and has probably been stimulated by factors as diverse as the rhetoric of crisis in rural health care and the presence of individuals with interest and commitment to rural nursing (as Valintine exhibited in the early years of the twentieth century). Also of relevance is the recognition by

government that nurses may have more to offer health care than has historically been allowed by the structures they have been employed within. There is also, of course, the undeniably increasing need for the accountability of health professionals across the health service which has given rise to attempts to describe scopes of practice fairly tightly in order to attempt to control practitioner competency. In the case of rural nursing, tight definitions of scopes of practice are, quite obviously, difficult to achieve.

The influence of the National Centre for Rural Health in Christchurch, that operated between 1994 and 2003, providing courses, mentoring and support, is of key importance in both the increased visibility of rural nursing and the consolidation of a rural nursing identity. Formal postgraduate education for rural and remote nurses did not appear at the Centre until 1998. The Centre was closed in 2003 when tenders were let for the provision of postgraduate education for rural nurses and the centre was not a successful bidder. Other providers have since taken up rural nurse continuing education. However the impact of these courses on the professional identities of nurses who completed the Diploma or the Certificate cannot be underestimated. Further discussion of the contemporary context is, of course, the subject of this thesis and will be dealt with in depth in the chapters that follow.

### **Non-hospital nursing in the United Kingdom**

In the United Kingdom, it is very difficult to locate the exact beginnings of nursing outside of hospitals. It is easier to date the beginning of some type of formal training for what were called 'district nurses'. In 1859 William Rathbone of Liverpool, who Stocks (1960) calls 'imaginatively charitable', began an experiment which was to lead to the development of a comprehensive, trained district nursing service for Britain,

whose attentions were directed to the sick poor, as opposed to private nursing. In a similar fashion to New Zealand, the ‘character’ and ‘class’ of these nurses was, at least initially, of utmost importance, since they were not only to bring nursing assistance but also ‘order’ and ‘cleanliness’ to the poor. The nurses were initially funded by subscriptions, as was the Nurse Maude District Nursing service in Christchurch. On the Jubilee of Queen Victoria (1887), a large sum of money, which came to be known as the Queen’s Jubilee Fund, was raised by women and was largely dedicated to district nursing, with the nurses becoming Queen’s Nurses; their local organisations affiliated with the Queen’s Jubilee Institute. Association with the Institute required that nurses firstly adhered to the training requirements and secondly that nurses did not interfere with the patient’s religion (Stocks 1960).

Stocks (1960: 92) indicates that the history of rural and parish nursing is obscure but she believes that a very similar pattern of single handed nurses would have been found in the small villages as were to be found in the slum parishes of London. Prior to the Queen’s Jubilee Institute, Mrs Elizabeth Malleson of Gloucestershire, had canvassed support to form “an Association to supply Trained Midwives and Sick Nurses (for non-infectious cases) in districts remote from medical aid” (Stocks 1960: 99), the outcome of which was the Rural Nursing Association which came to be affiliated with the Queen’s Jubilee fund, to become the Rural District Branch in 1890 (ibid: 101).

Friction between district nurse/midwives and doctors was particularly evident in rural areas and also doctors were beginning to attempt to limit the practice of district nurses by suggesting that “no nurse should be allowed to administer or prescribe any drug on her own responsibility” (Stocks 1960: 121). Country areas, it

also came to be realised, were not always amenable to policies formulated to apply in urban environments. Many areas were making use of a 'village nurse', who had only been trained in midwifery. This practice was directly counter to the training policies of the Queen's Jubilee Institute but over time these nurses were replaced with Queen's Nurses (ibid: 123). Queen's nurses were to be found as far afield as the Western Isles of Scotland and Shetland.

In 1919, State Registration of nurses was achieved, with its attendant examinations and regulations. Educating the patient in the "principles of healthy living" (Stocks 1960: 159) had always been the preserve of the district nurse, but this intensified focus on public health was operationalised in the 'health visitor'. By 1925 by doing a six month course, it became possible for the district nurse to provide, general nursing, midwifery (if trained), and health visiting. When performed by one person, an integrated service was provided to the community (ibid: 160).

In 1948 the National Health Service (NHS) was born, as part of the new welfare state. Under the National Health Service Act 1946, local health authorities were "required to provide nurses to attend persons requiring nursing in their own homes, free of charge" (Stocks 1960: 172). Different areas of the United Kingdom varied in the use they made of the existing voluntary district nursing associations, with some utilising these and taking over the costs of their running, while other areas provided their own nurses, ignoring the existing systems.

As far as I am aware there has been no dedicated rural or remote nursing role in the United Kingdom. But, the European region, including the United Kingdom has joined the worldwide trend to a shift in health care focus towards public health and primary care. Part of this shift has been the description and support of a new nursing

role; the Family Health Nurse (FHN) in 1999, as a need for a generalist primary care nursing role was identified by the World Health Organisation's European Office, (hereafter, WHO Europe). The implementation of this nursing role was one of the objectives of WHO for the biennium (WHO 2003a). The role was/is to have parity in status with general practitioners (Kesby 2000: 117). At least part of the stimulus for the setting up of this role is to address the health care needs of rural areas, and it is in rural and remote areas that the role has been piloted. While not exactly the same as the remote nursing role in New Zealand, the Family Health Nurse role makes an interesting satellite study due to the intentionality of its development and the breadth that the role encompasses. The pilot is most well developed in Scotland, which already had eight nursing disciplines providing community-based nursing services (WHO 2003b: 2). The introduction of another role has been potentially problematic and it has also been poorly understood by other members of the health care teams. Further discussion of this role is reserved until chapter seven. But it is important to move at this point to a discussion of the conceptual framework within which nursing, in both New Zealand and the United Kingdom, has recently been located. I pay particular attention to the problematic nature of care work and the struggle for professional status since this discussion provides crucial context to the bind in which contemporary nurses find themselves.

### **Vocation/Care/Profession**

Nursing has traditionally been seen as a, usually secular, calling or vocation. The transition from the 'Sarah Gamp' figure of Dickens to that of a respectable middle class woman was not unproblematic. Earning money decreased a woman's status in the mid to late 1800s and in order to recover status to some degree, Nightingale's

“trump card ... was linking nursing to altruism – to the high status of philanthropic ladies such as Nightingale herself, and to the religious vocation of the nursing nuns” (Godden 1997: 184). A clear notion of nursing as a vocation comes through in the writings of Elizabeth Glover, a high profile nurse in Australia in the early 1900s, who notes:

A nurse’s life is hard and full of self sacrifice .... We must not measure our hours of labour, but rather regret that we cannot do more .... A good nurse can never be compensated by money. She must be paid ... but her work must be something better, something higher, and I may add purer and holier than the ordinary commerce of today (Godden 1997: 181, citing Glover).

It will be no surprise to learn that Glover opposed the eight hour day in Australia as something appropriate to ‘trade’ but not to nurses who “were professional women who would work for the benefit of mankind [sic] all day if necessary” (Godden 1997: 180).

‘Vocation’ “epitomised the belief that nurses brought not only natural skills to their chosen occupation, but also deeper qualities of giving and lack of interest in financial reward” (Smith 1992: 30). Davies (1995a) suggests that much of this type of thinking has rested upon idealising care by women in the home, which guaranteed its underanalysis, since if something is considered to be ‘natural’ then it can be constructed as beyond question.

Hard to define, and almost impossible to measure (Davies 1995a), the notion of ‘care’ is central to nursing, but as well as being central, it presents nursing with a dilemma. If care is an inherent trait of women, then it cannot also be considered a skill. As Reverby (1987: 1) argues, nurses are ordered to care in a society that refuses to value caring. Low wages, and/or no wages for so-called ‘care work’ are evidence of this lack of economic value. Although the economic arena is not the only arbiter of value, it is nevertheless a very powerful one. ‘Care’ is a word that has a long and

tortuous history in both feminist and nursing literatures in which the so-called ‘care debates’ have raged and continue to do so. The debates have given rise to an enormous philosophical literature that deals with ethics, care and justice (see Gatens 1998).

Some early second wave feminist work argued for the re-valuation of the concept of care as a feminine property (a gynocentric perspective), with all the essentialising tendencies inherent in that project. This early work often drew on the arguments advanced by Gilligan (1982). Writing on care and its association with women, Gilligan argued that there was a distinctively feminine moral ‘voice’ in relation to care (see also Noddings 1984). To a large extent the debates have shifted and become more complex. But in a critique of Gilligan’s work, Moody-Adams noted a leap from an empirical generalisation about behaviour, to claims about moral capacities (1991: 198). Some commentators have read Gilligan’s ‘different moral voice’, as actually suggesting a superior moral voice, even though Gilligan insists that this is not the aim of her work (Gilligan and Wiggins 1987). Arguing that there is a superior feminine moral voice in relation to care, reinforces ideas of women’s ‘natural’ fitness for domestic and caring labour, both in the home and in nursing. Indeed, in nursing one of the attempts made to distinguish nursing from medicine was to draw on an ‘ethic of care’ to assert this difference. Some critics of Gilligan’s work suggest that the conclusions that she has drawn from her findings are problematic. Lloyd (1983, 1984) for instance has “asked whether the very idea of a distinctively feminine moral character is perhaps a *product* of the very intellectual traditions to which it purports to be a critical response” (cited in Moody-Adams 1991: 211. Emphasis in original). Despite these debates, it remains undeniable that femininity is associated with care (Brush 1999).

One of the key ways that the move to professionalise has functioned is to make claims to a specific body of knowledge and skills that ‘belong’ to the nursing profession. Abbott and Wallace note that nurses have had trouble identifying “an autonomous knowledge base, to underpin an area of work where they are perceived as experts” (1990: 24). But, Thornley, following Clay, says that the professional model “usually draws on the more technical field of acute care to argue that nursing requires a ‘certain level of intelligence, skill and knowledge’ and can no longer be compared to nursing of the past” (1996: 173). This representation of nursing work moves it further away from the routine, domestic tasks that have been part of nursing historically. But the focus on the specialised area of acute care as a type of benchmark for skill is of particular relevance for this study since much of the nursing work that rural nurses do is not highly technical, and is best categorised as generalist rather than specialist work. If ‘acute’ and ‘technical’ are the skilled part of nursing then there may be a tendency for the less technical and acute areas of nursing work to become peripheral and de-valued, or simply to be poorly understood.

Within nursing’s professionalisation project, care occupies an ambivalent position (Savage 1999). The professionalisation debates (with their focus on skill and expertise) seem to place care in a peripheral position. Waerness provides an explanation as to why care may be pushed to the periphery in this way; she notes that:

because the head-heart duality is accepted in all sciences, it seems probable that any kind of formal education based on scientific knowledge will to some degree promote a more instrumental attitude towards work, at the expense of the expressive (1992: 223).

But, Davies challenges this solely dichotomous construction by insisting that nurses “frequently face the issues of reconciling professionalism and caring as dilemmas of daily practice” (Davies 1995a: 145). Care for nurses encompasses both the skilled

tasks required in order to administer drugs and treatments plus the physical tasks which include body care as well as the emotional labour (Hochschild 1983) which is also a major component of nursing. These things are not separate but very much intertwined in the provision of full care for a patient. Davies suggests that the care work that nurses do crosses the boundary “between the rational action that is appropriate for the public domain and the intimacy which our gendered thinking reserves for the private and domestic one” (1995a: 146). The paradoxical nature of nursing work is highlighted in Smith’s discussion of care. ‘Concepts of care’ according to Smith:

are fraught with contrasts and contradictions. Is it labour or is it love? Is it natural or is it a skill? Is it about feelings or tasks? Does it come from the heart, the head or the hand? Is it guided by mind or body? Or should caring be seen as an integrated whole? (Smith 1992: 10).

An attempt to give substance to, what Smith has called an ‘integrated whole’, is evident in the concept of holism that has been widely drawn on in nursing. The rise of the concept of ‘holism’ in nursing dates back to the 1950s and 1960s when the spiritual and psychosocial dimensions were identified as desirable additions to a purely biomedical approach to patients. Boschma suggests that this “holistic patient-centred approach can be seen as [another] ...professionalising strategy with which to distinguish nursing from medicine” (1997: 170), and holism was a direct challenge to what was seen as the reductionist tendencies of bio-medicine. However Boschma goes on to say that the focus on the psychosocial served to provide holism with a gender bias:

The paradoxical nature of the holistic patient-centred care concepts was that their description still resonated with the older idea of nursing as a higher female calling ... when it was the nurse’s female characteristics in particular that made her fitted for the job (1997: 172).

The complex genealogy of nursing: gender, vocation, profession, labour, love, the instrumental and the expressive are all part of the complex legacy that contemporary nurses call their history.

### **Concluding Comments**

The key themes that emerge from this predominantly historical analysis fall into three categories that all have implications for the way that nursing in general, and rural nursing in particular comes to be governed. The first theme was that of the hospital-based training of the moral character of the nurse. The second theme explored the escape from the hospital when nurses moved into community work. The third theme addressed the way that contemporary nursing engages with the problematic nature of the concurrent utilisation of notions of vocation, care, and profession.

The way that nursing has developed, particularly in relation to medicine in the medical division of labour has historically positioned it as subjugated knowledge. But in some sense this subjugation was the price paid to be part of the division of labour at all, since paid work for women, especially middle class women, was not the norm in Victorian times and was looked on with some suspicion. In order to make paid work as a nurse 'respectable' it was often looked on as a vocation, much like a religious vocation and ideally the moral character of the nurse would be impeccable. Although the way that this character was controlled was by fairly constant direct surveillance, the goal was self-policing in both clinical and moral terms.

For nurses who had moved away from hospitals to work in the community this direct surveillance was not available and so the ability of nurses to police their own conduct was relied upon. In settings such as rural areas the extended clinical practice of nursing caused concern amongst doctors who feared encroachment on to their medical territory. The boundaries between medicine and nursing apparently needed to

be constantly policed, especially where nurses did not function within the highly controlled confines of the hospital where clinical roles are harder to demarcate in an absolute sense. The boundaries between medicine and nursing are, in spite of much effort to police them, hard to fix.

In the struggle that nursing has engaged in to professionalise, the ‘conundrum of care’ has dogged these efforts often pushing nursing towards a focus on the high technology parts of nursing to assert credibility. The high technology parts of nursing are those closest in nature to medicine. But constructing nursing as that which is carried out at the high technology end of the spectrum is a very limited and limiting way of conceptualising nursing practice. The difficulties with defining and measuring what nursing is and does, at least partially because of its association with the notion of care, present ongoing problems for nursing as it attempts to assert claims to significant space in health care delivery in ways that are distinct from bio-medicine. Rural nursing with its more autonomous practice challenges interprofessional boundaries and disturbs intraprofessional boundaries by practising a number of otherwise specialist nursing roles concurrently. This advanced role is about a great deal more than a simple increase in tasks, rather as Ross (1999: 253) argues; it is about changing the “very character of nursing”. Changing the character of nursing also means changing the means of governing nursing expertise and practice.

Governing the rural nurse takes place at a number of spatial scales from the ideological, as has been demonstrated in this chapter, to the legislative as will be demonstrated in the next chapter. Complexly formulated discourses of trust and law, within the discursive field of risk, permeate the narratives of rural primary care nurses, particularly when they discuss issues surrounding prescribing and administering pharmaceuticals and making clinical judgements. The focus in the

following chapter is predominantly on risk and to a lesser extent strategies of professional regulation.

## Policy and practice: Risk, Trust and Law

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### Introduction

In the contemporary health care climate, one of the mechanisms for the regulation of professional conduct is the ‘shadow of the law’, stimulated by a new and increasingly pervasive litigious mentality (Rose 1996; Dingwall 1994). This shadow under which health professionals practise takes a particular form in rural health care where nurses function at the bounds of usual (urban) nursing practice, so stretching definitions of legality and relying on informal systems of trust. This stretching of definitions of legality thus gives rise to a particular geography of law that reworks the taken for granted legal boundaries constructed in urban settings. Technologies of performance (Dean 1997) designed to render health care practice auditable and governable by confining scopes of practice<sup>13</sup> are seen to be blunt instruments in rural primary care nursing practice due to the ways that this practice escapes conventional urban role boundaries.

This chapter explores the ways that New Zealand rural primary care nurses utilise discourses of trust and law, within the discursive field of risk, to make sense of their ambiguous professional positioning with regard to clinical decision making in

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<sup>13</sup> A scope of practice is a professional clinical domain across which a nurse is deemed competent to practise.

the context of their work. Here the focus is specifically on the ways that rural nurses govern their professional conduct in order to manage risk. Using the literatures on risk and its relationship to governance more generally, and then applying these to the specific situation of health professionals, the chapter considers three broad areas that influence the work of nurses in terms of the complexity surrounding clinical decision making. The chapter begins by exploring the notion of risk itself before moving on to look at the problematic nature of 'standing orders' as a means of 'legalising' practice and introduces the Primary Response in Medical Emergency (PRIME) role. This section examines the ways that nurses attempt to make sense of the unclear legal position that they are in and how they manage clinical risk. The second major section introduces the concept of trust as a means of managing risk and investigates the ways that nurses work with trust in their interactions with doctors in order to facilitate practice. The final major section deals with the newly developed role of nurse practitioner, nurse prescribing, and the Health Practitioners Competency Assurance Act all of which rely for their 'safe' functioning on tightly defined scopes of professional practice in order to attempt to contain 'risky' professional subjects. This section begins by unpacking the ways that the nurse practitioner role, while seemingly able to address some of the confusions and areas of questionable legality that mean that nurses must deal with higher levels of risk in rural clinical nursing work, is not an easy status for rural nurses to achieve. The nurse practitioner role also relies upon defining a discrete area of practice in which a nurse is competent to work. Defining a scope of practice for rural primary care nursing is extremely difficult due to the extensive breadth of their work roles.

Nurses have been constructed as 'risky subjects' when they extend or expand their practice as they do when they undertake rural primary care nursing, the nurse

practitioner role and nurse prescribing (which is an optional component of the nurse practitioner role). One of the ways that attempts have been made to manage the risk of these potentially risky professional subjects is to define and confine their scopes of practice in an attempt to better judge what specific professional practice is appropriate in a particular setting and by a particular practitioner. This definition of scopes of practice is a core component of the Health Practitioners Competency Assurance Act. Health care practitioners whose work crosses specialised disciplinary, or scope-of-practice boundaries are presented with an immediate problem, which is difficult to resolve. Herein lies the tension that is explored in this chapter; rural primary care nurses' work crosses both inter and intra professional boundaries and, as such, they participate in professional practices that are often not well supported by policy and legislation. Nurses are thus 'exposed' to risk to a much greater degree than are their counterparts in the urban environment. While these practitioners do not appear to be prone to higher levels of disciplinary action, they practice in a climate of risk that serves to heighten anxiety.

### **Notions of Risk**

The concept of risk in health care more broadly has usually been tied, in biomedical terms, to 'risk factors' for the potential to develop disease (epidemiological risk), and in terms of critical theory, to the ways that citizens in the contemporary state under neoliberalism, are expected to manage their own health risks (Petersen 1997; Nettleton 1997; Lupton 1999). For health care practitioners, risk has most often been framed within medico-legal discourses and the risk of practitioner error, or in terms of health and safety at work and the risks attached to such things as needle stick injuries.

The notion of risk has received extensive attention in the academic social science literatures (Beck 1992; Douglas 1992; Giddens 1998; Adam et al. 2000), and specifically in the field of health (Annandale 1996; Lupton 1997, 1999; Nettleton 1997; Petersen 1997; Turner 1997). The very fact that the concept of risk has received so much attention reinforces the pervasiveness of the notion, however it has been conceived of in different ways. Lupton (1999: 35), for instance, identifies three different approaches to the understanding of risk. Firstly, the technico-scientific which perceives risk as an objective hazard that exists and can be measured independently of social and cultural processes. Secondly, the risk society and cultural/symbolic perspectives which conceptualise risk as an objective hazard in a similar fashion to the technico-scientific approach, but rather than seeing hazards as measurable, this approach conceives of them as “mediated through social and cultural processes” (ibid). And finally, the governmentality perspective that maintains a position in which nothing is a risk in itself, but rather what we come to understand as risks are products of historically, socially and politically contingent ‘ways of seeing’. Dean (1997: 217) argues that all of the above ways of defining risk depend upon the calculation or probability that harmful or dangerous events might occur. But understanding risk as a ‘way of seeing’ means that the terms of engagement are shifted from a desire to define the ‘real’ nature of risk, towards explorations of the different ways that risk is calculated and on which moral and political contingencies these calculations draw (Dean 1999: 131). It is this latter formulation of risk that is utilised in this chapter.

The notion of ‘risk’ surrounding pharmaceuticals is a very good example of the contingent nature of risk. The occupational group that claims the ‘right’ to control the prescribing of drugs is historically contingent. Although Walby et al. (1994) indicate that historically, and as a general principle, doctors prescribe drugs and

nurses administer them, the control over drug giving has relatively recently become the province of doctors. In the later part of the nineteenth century in New Zealand, Belgrave (1991) notes that while there was some degree of role specialisation between doctors, chemists and nurses, their roles were quite blurred. Roles were blurred in so far as “both nurses and chemists diagnosed and treated sickness independently of doctors, and it was not unusual for doctors to provide round-the-clock nursing attendance for wealthy patients” (Belgrave 1991: 10). Gradually the roles of chemists, doctors and nurses have been solidified around pharmaceuticals, with doctors prescribing, chemists dispensing and nurses administering them. By constructing themselves as the group authorised to prescribe drugs, doctors are able to construct others (such as nurses) as unauthorised.

#### Standing (dis)orders: negotiating risk

Up until very recently no nurse could prescribe medicines in New Zealand. But, many nurses in a variety of work situations worked under ‘standing orders’, and have done so for decades. Standing orders consist of *written* instructions, “normally issued by a medical practitioner, to allow delegated persons, such as ambulance officers and nurses, to administer medicines to patients in the medical practitioner’s absence. The details of standing orders vary from provider to provider” (MOH 2000: 1). Most of the rural/remote nurses in this study have practised, and a few currently practise, under standing orders. However, concerns were expressed by the Ministry of Health and the health sector about the standard of some of these standing orders, and what their status in law was under the Medicines Act 1981 (ibid: 1). It is not clear who in the health sector was concerned about the standard and legality of standing orders, but suffice to say, once the concern had been acknowledged then clarification became

imperative (Ross, 1998). Ross's particular concern was for rural nurses because of their already advanced role and the need to give drugs in the context of their normal work, particularly in emergency situations.

At the time of the bulk of my research (early and mid 2002) there was little if any certainty in regard to the legality surrounding the prescription, supply and administration of drugs for/by rural nurses, although each nurse interviewed had worked out some system that they felt 'safe' to use. The prescription of medicines usually requires the close proximity of a medical practitioner. Rural/remote primary care nurses do not usually have a doctor on-site, therefore how medicines end up being distributed is often very complex. The work practices of rural nurses who work predominantly without doctors have been altered, for example, when District Health Board Managers will not support the use of standing orders until clarification of their legality is achieved:

*A lot of us were actually practising under standing orders until all of a sudden it was whoah neddy and then it became critically important that people weren't practising under standing orders, so that it didn't jeopardise them becoming legal, so there was a great holding back ... . It's just ridiculous, and we were told in 1998 that they [standing orders] were just around the corner. We didn't realise that it would have such a huge bend in it, the corner (Rural registered nurse. 2002).*

Once concern had been expressed about standing orders, the period of time taken to clarify their status was lengthy and left nurses "out on a limb", managing the risk of pharmaceuticals on a daily basis without legal backing<sup>14</sup>:

*We all know the procedures, we all know what needs to be done, but we are not legally covered from doing it, whereas something like initially bringing in a standing order that was certified by the doctors that you liase and work with would simplify it, but until it goes through government, who outlawed standing orders, like, honestly, it's crap, it really does make your job a lot harder than*

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<sup>14</sup> I am not concerned here about 'truths' surrounding legality, but rather what nurses perceive to be the case.

*it needs to be, well it leaves you out on a limb a lot more than you need to be* (Rural registered nurse. 2002).

So while the Medicines Amendment Act, enacted on 14 October 1999, enabled the making of regulations under the Medicines Act 1981 for the use of standing orders, these regulations were not actually formally achieved until November 2002. Following on from the making of regulations there was a further delay while District Health Boards, Community Trusts and individuals worked out how they would apply the regulations.

In the absence of standing orders the ‘need’ to provide medications to patients did not go away, hence other informal systems were relied on. The main methods used were verbal orders obtained from doctors by telephone, and faxing scripts to doctors to sign and send back. In a few cases nurses indicated that the community had fundraised for them to buy fax machines. Ironically it is by means of fax that many remote nurses send scripts to doctors to sign. Thus it can be argued that while one District Health Board told nurses to back off standing orders, they did not then provide a fax machine that would enable nurses to “legalise” the administration of drugs:

*I had to pay for my fax machine out of donations a few years ago because they just said they [the District Health Board] didn't have the funds for that* (Rural registered nurse. 2002).

Although it is quite unclear where the notion originated, nurses indicated that they were not ‘legally’ allowed to even suggest that a patient take a medicine:

*I mean legally I can't give an aspirin to a person in chest pain without ringing the doctor to say, can they have an aspirin?... you get very good at getting around things like that. Like asking the wife if they've got any aspirin in the cupboard that she might like to give her husband...[and doing] that actually covers [you], but you shouldn't have to do things like that* (Rural registered nurse. 2002).

On the other hand the following nurse is quite happy to give out over-the-counter drugs (OTCs) such as aspirin:

*I give out over the counter medication without a prescription, or without having to go through the doctor. If somebody has got a back pain and they need an anti-inflammatory and they have had it before, and they haven't got asthma, I'll give them voltaren 'cause you can buy that over the counter (Rural registered nurse. 2002).*

For some employers the decision-making that goes on around drugs is simple and clear cut. However the conflict between different interpretations of 'appropriate conduct' is obvious when a nurse in day-to-day work is supposedly not 'covered' to suggest that a drug that can be bought over the counter should be taken. Furthermore, when attending a patient as a PRIME provider, the nurse would be considered negligent if the drug were not administered:

*My reliever was told by our manager recently that she should not have given a person an aspirin when they were having a heart attack....but as I said to her, there's ways around it. You could have given it to his daughter and said "your father needs an aspirin, would you give him an aspirin?" There's ways around it but [colleague] will be deemed by nature of the PRIME contract to have been absolutely and utterly inappropriate for not giving it [Rural registered nurse. 2002)*

The absurdity of the situation regarding what nurses may and may not do, and when, is well highlighted by one nurse who is also a midwife:

*The thing I laugh about most is the pharmacology, and the nurse prescribing. I think it's just such a farce...with my LMC [lead maternity carer] hat on I can treat urine infections, give out contraception prescriptions, do all sorts of things with prescribing. I have a script pad and all of that, but if someone comes into the practice...that's not pregnant and I'm not LMC for, I can't do any of that. Oh, come on! (Rural registered nurse. 2003).*

Nurses are able to supply medicines on the strength of these communications using supplies of drugs in the clinics that are provided under the MPSO (Medical

Practitioner Supply Order)<sup>15</sup> scheme. Both verbal orders and faxed scripts rely on what the nurse has told the doctor about the patient and *not on the doctor seeing the patient for themselves*. Although some nurses construct the obtaining of a verbal order to be a ‘safer’ course of action, the status of verbal orders is also legally unclear. In normal circumstances “no doctor should prescribe medication to a patient *unless the patient has had a face-to-face consultation* with the doctor or another medical practitioner who can verify the physical data and identity of the patient” (Medsafe, 2002. Italics mine. No page numbers). While this is the official legal position, the contingencies of rural practice make this impossible to adhere to, and extensive use is made of verbal orders. The use of verbal orders places the nurse in the position of embodying the doctor. The nurse becomes, as one nurse actually articulated, “his eyes and ears down here”. Having given a drug order verbally, the doctor would normally then sign a prescription form at a later date. The taking of verbal phone orders from doctors involves a high degree of trust between practitioners. Giddens argues that, “because of its inherent connection with absence, trust is always bound up with modes of organising “reliable” interactions across time-space” (1990: 100-101). This setting up of ‘reliable’ modes of interaction across time and space is nowhere more evident than in the ways that pharmaceuticals are managed in rural and remote places. ‘Reliability’ is also strained in some instances.

One area that caused nurses anxiety was the difficulty they faced when presented with a problem that required either permission to give a drug, or medical advice in areas of poor or non-existent telecommunications. This link (telephone) that ‘legalised’ practice could no longer be relied upon and the nurse was left to make decisions autonomously and to pick up the pieces later:

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<sup>15</sup> MPSO is a supply of emergency and those drugs deemed essential, which are provided to Medical and Dental practitioners funded by government.

*Not that we should admit to this, there are certain things that you would give and then seek permission, but if I was in a case that I knew I couldn't get help, I would most probably go ahead and give it and then find a doctor and then sort it out but then legally that doesn't cover me, legally that leaves me out on a limb. I mean I could be de-registered for practice like that because you're not legally allowed to be giving anything like that (Rural registered nurse. 2002).*

Nurses have professional indemnity insurance available in much the same way as doctors do. But nurse after nurse indicated that they felt that the nurses' disciplinary body was much 'harder on their own' than was that of the doctors. One nurse cited the example of a case where a doctor's work was affected by his alcohol use. The doctor was still in practice. This nurse's impression from reading the disciplinary column in the New Zealand nursing journal; *Kai Tiaki*, was that a nurse would only need to be affected by alcohol once on duty to be dismissed.

Although the following nurse who was relatively new to on-call work had not yet been in a situation where an autonomous decision had to be made regarding the giving of a drug, the nurse was willing to speculate on action:

*I would do it and sort it out later...with knowledge of your medication and body size and all of those things and whether the person has had it [the drug] before, if they could answer you, then you'd decide on how much you were going to give them. But in an emergency situation I don't believe that we'd have too much difficulty in justifying your actions. I think you would have to justify your inaction more strongly than you justify your action and particularly if you documented everything very well and when you got into Telecom contact again with something like A&E, I would ring them and tell them what I had done as well as sending them the top copy of the information of everything I had done as well, so it was well documented, and they knew exactly what you had been doing (Rural registered nurse. 2003).*

The above nurse working autonomously and outside the bounds of legality, although within the bounds of duty of care, attempts to make practice auditable by documenting and reporting on what has been done. In most cases when nurses are

likely to be faced with the above situations, they are likely to be working in the context of PRIME.

## PRIME

All but two of the nurses in this study are part of the Primary Response in Medical Emergency (PRIME) scheme. This pre-hospital care role is one of the distinct features of rural/remote nursing. The PRIME scheme was developed in 1995 in order to provide coordinated response and consistent, appropriate management of trauma and medical emergencies in rural locations (Hore et al. 2003). The scheme was trialled in the then Southern Regional Health Authority region in 1998, and extended to the rest of the country in 1999 (ibid). Both rural nurses and doctors are involved in the scheme and must complete a specialised training programme recognised by the New Zealand Accident Compensation Commission (ACC) and complete a two-day refresher course at least every two years. The PRIME scheme “utilises the skills of rural GPs and/or rural nurses (RNs) in areas where an ambulance crew (two ambulance officers, where one is a paramedic) is more than 20 minutes away (40 minutes in the South Island)” (Hore et al. 2003: 2). There are in fact very few volunteer ambulance officers trained to paramedic level via St Johns (the ambulance service providers and trainers in New Zealand), in remote areas.

The regulations surrounding PRIME state, among other things, that the service is to be available seven days a week for twenty four hours of the day. Ex-rural GP, Murdock (2002) is critical of the requirement to provide twenty four hour, seven day a week cover. Murdock suggests that “the worst thing that ever happened to rural practice was this concept of 24-hour cover” and he goes on to cite the late Eric Elder (a rural GP from Tuatapere), whose:

philosophy was that he lived in the community and if he was around, he could be called, if he had to go to Winton to play cricket, or to Invercargill to teach registrars, he wasn't there. Since that time the burden of being there has increased with modern communications as well as modern approaches to resuscitation, and it is doubtful whether we can do it all. We have to ensure that involvement in after-hours care can be a voluntary choice for the rural doctor rather than a blanket responsibility. Hopefully the Medical Practitioners Disciplinary Committee and the Health and Disability Commissioner will be aware of these changes and modify some of their decisions which assume that being a general practitioner implies 24-hour responsibility when things go wrong (Murdock, 2002: 76).

As well as providing a twenty-four hour service, the PRIME service provider must have and maintain access to a cell phone, or other communication approved by the PRIME committee such as an ambulance radio, for use in a PRIME emergency (ACC, undated). Further to this, the regulations also state that:

on occasions that registered nurses are on call for attendance at PRIME emergencies, the employing PRIME service provider is to ensure that the registered nurse has 24 hour access to a registered medical practitioner who can provide her/him with appropriate medical advice by telephone (ACC undated).

Yet, taking into account the problems with telecommunications in some areas, it is not always possible to access this backup and another catch 22 presents itself to the nurse:

*In the PRIME training, I can actually face litigation if I don't give a drug to a person despite the fact that I can't get hold of a doctor to get permission to give it. Or I can't get a doctor to give me permission (Rural registered nurse. 2002)*

Paul Davey, clinical skills educator on the PRIME programme for the northern region of the South Island, acknowledges problems with telecommunications, but he says that ambulance radios are gradually being provided for PRIME responders. These radios have better coverage than cell phones, but coverage is still not complete. While not wording it as strongly as the nurse above who suggests that litigation may be faced for inaction, Davey is clear that he would expect the nurse to act at the time and

then document what had been done, rather than not act. Davey's preferred way of dealing with this seeming anomaly is to issue all PRIME providers with booklets of protocols and standing orders that would obviate the need for nurses to obtain phone backing from doctors in many cases. These booklets are to be issued to all PRIME providers in 2004 (Davey pers. com 2003). The standing orders that PRIME providers (under the umbrella of St Johns) work with, are distinct from those that nurses had utilised in their practice prior to concerns being raised about their status in the late 1990s. PRIME and St Johns standing orders were unaffected by the uncertainty surrounding those affecting nursing.

To some extent the requirement to have twenty-four hour backup by telephone from a medical practitioner is anomalous, because it reconstructs the nurses who carry out PRIME roles as a form of dependent practitioner. I am not interested in arguing about the appropriateness of this positioning, but rather to identify the mixed messages that it promotes in terms of professional responsibility. There has been some confusion regarding who carries liability for decisions made by PRIME nurses. This confusion has possibly occurred because nurses have, in primary health care and hospital practice, had to seek the backing of doctors to give drugs. Whereas within the framework of PRIME, although nurses are supposed to be able to contact doctors for backup, the system relies on quick decisions in emergency situations and is not seen as dependent practice, in which the nurses would have to obtain permission from the doctor to act. This confusion is played out in practice. One doctor contacted Davey and suggested that a nurse in his area should not be a PRIME provider because the nurse 'didn't have what it takes'. It was pointed out to the doctor that it was not his responsibility. Within the framework of PRIME, nurses are fully responsible for their own individual practice, as they are in all other settings as well.

Davey noted that there have not been problems, as there have been in other clinical settings, with the standing orders that St Johns staff and PRIME providers work with. These standing orders have been in operation for twenty years. Interestingly, when compared to other health care providers, St Johns has only rarely reached the news on medico legal matters<sup>16</sup>. Davey attributes this to the strict protocols and structures that clinical staff work with.

For regular staff of St Johns the situation with regard to what they can and cannot do appears to be quite clear, but it can be argued that their role boundaries are a great deal clearer than those that PRIME nurses negotiate. As Davey noted, when training nurses in PRIME, the biggest challenge is to get them to ‘take off their nursing hat’, by which he means the insistence that nurses are not educated in diagnosis, and have sometimes been specifically told that their role is not to diagnose. The appropriate performance of the PRIME role does, unsurprisingly, require a differential diagnosis to be made prior to action being taken.

The need for nurses to wear several ‘hats’, each constituting slightly different professional identities is complicated. There appears to be little understanding of the tension these competing demands place on nurses, or of the complexity of the situation that nurses who work across scopes and contexts of practice deal with. Speaking retrospectively the following nurse articulates some of the issues that were faced on starting the rural job:

*I got threatened with all sorts of things, like I was threatened with that if I prescribed and somebody died or something went wrong and I got taken to court they [city-based supervisors] wouldn't support me. I went away and thought about it for a while and then I wrote back to them and said well that's fine, but I'll actually drag you into court with me because you're supplying the drugs and it's in my job description that I've got to do what's now PRIME, but*

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<sup>16</sup> An ambulance driver (a nurse who also worked at a South Island hospital) was recently (2004) charged with careless driving causing death when the ambulance she was driving crossed the centre line and killed the driver of an oncoming car.

*without any kind of equipping and I organised a lot of my own education, upskilling* (Rural registered nurse. 2003).

With the setting up of PRIME in a formal sense, some of these historical issues that were of concern to the above nurse's employer are taken out of their hands and placed with St Johns as the employer. But the extreme lack of clarity and mixed messages surrounding the supply of drugs really do require nurses to be highly reflective about the legal status of what they are doing, and further, to rely on alternative systems in order to facilitate their practice. Systems of trust are deployed by both nurses and doctors to attempt to cover the gap left in the geography of law.

### **Risk and Trust**

Lewicki and Bunker (1996) in their discussion of trust in the workplace identify three different types of trust, calculus-based trust, knowledge-based trust and identification-based trust. It is some combination of these that is played out in rural/remote nursing work. Calculus-based trust is premised on constancy of behaviour; people will do what they say they will because they fear the consequences of not doing so. This is a deterrence-based trust grounded in fear of punishment for violating trust, and rewards from preserving it (Lewicki and Bunker 1996: 120). This first form of trust is somewhat clumsy in thinking about the ways that trust is worked out in rural health care between nurses and doctors, but there are nevertheless echoes of its operation. It is the final two forms of trust that have more salience. Knowledge-based trust, say Lewicki and Bunker, "occurs when one has enough information about others to understand them and accurately predict their likely behaviour" and in identification-based trust, trust exists because:

each party effectively understands, agrees with, empathizes with, and takes on the other's values because of the emotional connection between them and thus

can act for the other. Identification-based trust thus permits one to act as an “agent” for the other and substitute for the other in interpersonal transactions (1996:119).

The relationship between trust and risk is made clearly by Giddens, who suggests that not only do trust mechanisms apply to the relationships between lay persons and professionals, but they also apply to professionals themselves. “Codes of professional ethics, in some cases backed by legal sanctions, form one means whereby the trustworthiness of colleagues or associates is internally managed” (Giddens 1990: 87). The ‘internal management’ of such things as pharmaceuticals occurs largely at a distance from the public gaze. For Giddens the “essence of professionalism is the distinction between ‘front-stage’ and ‘back-stage’ performance. It sustains a faith in the working of expert knowledge of which the lay person is ignorant” (cited in Misztal, 1996: 93). So although Rose says that, “audits of various sorts come to replace the trust that social government invested in professional wisdom and the decisions and actions of specialists” (1996: 351), in one to one interactions between professionals in the rural setting, trust is the mechanism that facilitates pharmaceutical practice, in the face of risk. That is not to say that audit is unimportant and it will be discussed later in another context.

Trust, however, does not prevent anxiety surrounding risk. Giddens indicates that, “if basic trust is not developed or its inherent ambivalence not contained, the outcome is persistent existential anxiety” (1990: 100). By existential anxiety, Giddens appears to mean anxiety, or potential threat to our very continued existence, perhaps a dread that something terrible will happen, and he goes on to say, “in its most profound sense, the antithesis of trust is thus a state of mind which could be best summed up as existential *angst* or *dread*” (Giddens 1990: 100). While largely managing to contain ambivalence, nurses must negotiate within unclear bounds just what they are willing

to do, and there is certainly some sense of ongoing *angst* regarding decision making surrounding drugs.

Walby et al. (1994) indicate in their study of hospital nursing in the United Kingdom, that the situation with regard to making a nursing decision to give a drug was complex. They say that many junior doctors perceive a nurse who conforms to a rule that forbids verbals (an instruction to give a drug based on a verbal rather than written communication) as someone who will not accept professional responsibility. For some nurses, refusing to accept the authority of rules regarding the use of verbal orders is clear evidence of unprofessional behaviour. In a similar fashion to the analysis of Walby et al., the following nurse has to choose between making a decision to prescribe without consultation, or to gain a verbal order, and concludes that it would be unprofessional to act without that verbal order in spite of the doctor suggesting that s/he does. This nurse simultaneously does not accept the doctor's authority to give permission to give drugs without consultation, at the same time as placing at the forefront of decision making, the nurse's own notion of where professional boundaries lie:

*basically the doctor I work with says "... I know you and you know what I'll use, go ahead and do it". But I don't, I really don't. I want to be here for the long haul and I believe professionally it's not something that's in our scope at the moment. So for now I'm pretty determined to keep it like that. I would prefer to annoy [the doctor in] clinics and get [the doctor] hopefully, also, adding to the pressure to make some legal change .... (Rural registered nurse. 2002).*

Certainly for the rural nurses that were involved in this study, systems of trust with doctors that they worked with (however remotely) were extremely important, but not unproblematic. Systems of trust rely on on-going relationships between practitioners who do not have the same professional training and these relationships only develop over time. With high turnover rates of rural primary care doctors, developing trust can

be problematic. Systems of trust also do not have any legal standing, they are systems that are potentially able to be broken, since the doctor must agree at some point to sign for the drug that the nurse has been authorised to give on the strength of a phone conversation. There is no way of being absolutely sure of what was said in a phone conversation or in fact that the phone conversation even happened:

Nurse: *What we are going on here is trust, if I make a call, give out the medication, then the GP will sign for it.*

LT: So you hope that the GP will back you up?

Nurse: *Yeah. It's completely about trust. It's not legal* (Rural registered nurse. 2002)

Similarly, the following nurse said:

*The general practitioner that I work with [...] is absolutely excellent and we have a really good understanding of what we do, but I suppose legally it is certainly walking the gangplank a bit but we trust each other enough to know that like I know [the doctor] will back me up in scenarios that we have discussed about and talked about, so I mean I don't have a problem, but then still if he changes his mind I'm really out on a limb* (Rural registered nurse. 2002).

Although trusting that the GP will “back me up” the niggling uncertainty is clear in the negotiation of the liminal<sup>17</sup> space created in the ‘knowing’ on one level that what they are doing is not legal, but on the other agreeing to participate anyway for practical professional reasons. However, care needs to be taken in advancing the idea of liminal space, since this concept can obscure the power relations that are obvious in the ways that nurses are located in this space. Clearly it is the doctor who is assumed to hold the power to ‘back’ or not to ‘back’ the nurse, since s/he is ultimately the prescriber and thus bears responsibility for that. However if any situation regarding this issue were to come to a court of law, the prescriber (the doctor), would need to agree that they had given a verbal order to a nurse to absolve the nurse of

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<sup>17</sup> ‘Liminal’ is used here in the sense of ‘interstitial’ or ‘in-between’ space.

responsibility for a drug error. The way the doctor is positioned in the interaction is very clear in the following transcript:

Nurse: *We have a doctor who oversees our practice, who signs our prescriptions that we write for him on his behalf. We can contact him and talk with him any time or we can get any doctor really to send us over an order and get them dispensed according to that.*

LT: So it's a "trust" system?

Nurse: *Yes, it is and if we don't feel comfortable we might actually wait to get that order to actually do it but quite a bit of the time it's ... I mean we know what we're doing, so it's a retrospective thing. I've posted 30 prescriptions off this morning that we've done over the last ten days. Some of those will be consultations with the doctor but quite a few of them are repeats for people that we know what they're on, and the decisions that we've made according to what we've found.*

LT: Does that bother you?

Nurse: *No, it doesn't bother me because I know the doctor that oversees us.*

Systems of trust in rural health care tend to rely on individual knowledge of individual practitioners in relation to each other. In some areas nurses need to use the nearest hospital for the phone back up that they believe 'legalises' their practice. When the known, and usual doctor is absent and nurses need to make contact with other unknown doctors, trust is sometimes strained. One nurse works in the following way when the regular GP that is dealt with is away:

*If he was away for the day or on his days off, then we have to work with the hospital staff .... So what we do then is, I don't know them and they don't know me, so I get them to actually fax through a script and I put that in the patient's notes because they are not going to be coming to the clinic, they are not going to be physically here to do it [sign the script]. That just sits in the chart then and that's how it works (Rural registered nurse. 2002).*

As well as a relatively high turnover of rural general practitioners, hospital medical staff also change frequently, particularly in some of the smaller regional hospitals. These medical staff are often not aware of the area that the hospital they work in covers, and neither are they aware of the types of service that are provided outside of the hospital walls. This situation can lead to backup for nurses being either hard to get, or simply, inadequate:

*I think we often feel that, like, even down to who backs us up. Like we don't have that expertise of what we'd have at a main tertiary centre, you know, we don't have a paediatrician; we don't have registrars. I had one situation a few weeks ago where I had someone who was very, very sick. They had respiratory arrested so it was pretty scary stuff. I rang him and said, "look I need some advice" .... I was talking to the physician who was on-call and he said [nurse puts on an accent], "[rural area], oh you'd be quicker to go to [city hospital] wouldn't you, why you ringing me?" And I said " oh no, you are on-call for me, this is part of your area." "Oh no, I think you contact [city hospital], [city hospital] will be able to help you" ... and so in the end he acknowledged that I was part of the team but not before the third time I said to him, "no, [rural area] is part of [your area] and I'm closer to you. So that's what we are up against, you know they don't even know the boundaries....(Rural registered nurse. 2002).*

Another nurse was unable to get permission from a hospital doctor to give an intravenous drug that she considered was necessary:

*I put an IV in a patient and recently rang up to get permission to give some, it was a cardiac patient, to give some IV morphine and maxolon because we all know that if they are having a heart attack we can't streptokinase<sup>18</sup> them or anything like that if they have had intramuscular drugs ... This particular doctor said, oh no, I don't think it is safe for you to be giving IV drugs, so I had to give them intramuscular. I just couldn't get his permission to do it (Rural registered nurse. 2002).*

In spite of the problems encountered by these nurses, the general tone of nurses' comments about doctors and their support around the need to give drugs without the doctor actually seeing the patient face-to-face and prescribing them was positive. The everyday practices of rural and remote nurses though requiring constant recognition and management of medicolegal risk are facilitated by an imperfect system of trust between practitioners in most instances.

Of course there is an assumption within a culture and logic of risk that someone must be potentially blameable. Fox (1999) highlights the way that where once risk was a neutral term, it has gradually taken on negative connotations and has been placed in opposition to the notion of safety. I think it is fair to say that all health

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<sup>18</sup> Streptokinase is a drug that dissolves blood clots.

professionals are enmeshed in the terms of this dichotomy and it is unthinkable that a (sane) health professional should seek to practice in intentionally 'unsafe' ways. But, being within the terms of the safety/risk binary necessarily means that health professionals also become enmeshed in 'calculative regimes' (Dean, 1997), where they must constantly make assessments of the potential risks of their clinical decisions. Professionals thus become 'auditable subjects' (Surtees, 2003) in so far as they internalise the 'need' to obtain credentials, document, record, report, and reflect on their clinical practice, in other words, to govern their own professional conduct.

Both nurses and doctors inhabit 'calculative regimes', but having gained control over such practices as the prescription of medicines, doctors can 'construct' nurses as potentially 'risky subjects'. As Fox says, "the human subject of risk analysis is drawn into a *subjectivity* as 'risky' and perhaps culpable" (1999: 22). Thus while commentators have been at pains to point out that risk does not reside in a particular individual or group (Castel, 1991), in common practice, appeals *are* made on the basis of a danger that might be perceived to be located in a particular group or individual. This is evident in the ways that some groups in the medical profession have responded to nurses advancing their roles.

### **Nurse Practitioner, risky subjects and nurse prescribing**

To some extent a more mandated autonomous nursing role could address some of the anomalies, particularly a role that has the backing of legislation for areas of extended, or expanded practice, including prescribing. Following on from the report of the *Ministerial Taskforce on Nursing: Releasing the Potential of Nursing* (1998), the role of nurse practitioner was developed and trademarked by 2001. Part of the purpose of this trademarking of the name was so that controls could be placed over who could

claim the status (there have been nurses in New Zealand informally using this title for some years). The nurse practitioner role is the most advanced level of clinical practice and those who have supported the development of the role hope that it will help retain expert clinical nurses in New Zealand (Hughes and Carryer 2002). In order to be endorsed as a nurse practitioner a registered nurse needs to have a clinically focussed master's degree or its equivalent, to have met the Nursing Council's assessment criteria and competencies, and to have four or five years' experience at an advanced level in a specific scope of practice (Hughes and Carryer 2002: 5).

While the nurse practitioner role was developed for any scope of nursing practice at an advanced level, I would imagine that rural primary care nurses would appear to have a great deal to gain if endorsed as nurse practitioners. Gaining the status of nurse practitioner would release rural nurses from at least some of the informal systems of managing risk and utilising trust that they currently engage in with medical personnel, but of course, the relationship with patients always contains elements of trust as well.

#### Resistance from doctors

Certainly within the medical field there are those who are very anxious about the extension of nursing practice. It must be remembered that while these rural nurses have been doing these types of extended roles since the turn of the last century, with the increased accountability of health care work and the higher visibility and knowledge about extended nursing roles, a reaction is not surprising. A Christchurch Press article in 2002, quoted an individual doctor as saying that the idea of nurses taking on some of the roles currently done by doctors was: "very, very, scary". He goes on to say, "why don't they just do a medical degree? ...my fear is that they will

go out there and start practicing independently, not fully trained or supported, and that will be an absolute disaster” (Brooker, 2002: A5).

Beyond the level of individual doctors, Mackay (2003) found in her exploratory study of general practitioners’ perceptions of the nurse practitioner role that while doctors in the Northland region of New Zealand reported favourable perceptions of the role, they were nevertheless concerned, particularly, about nurse practitioners carrying out roles that have been their own preserve, such as prescribing, ordering laboratory tests and undertaking physical examinations. Doctors were also uncertain about legal liability for the nurses’ practice. Nurse practitioners are fully responsible for their own practice or malpractice (Mackay 2003). One of the most contentious areas has been that of prescribing.

Briscoe, Chair of the New Zealand Medical Association (NZMA), states that the NZMA’s concerns with the new nurse practitioner role related “mainly to nurses taking on new independent roles in medical areas for which we believe they may not have received adequate training”. She goes on to note that the NZMA’s concerns “relate principally to safety” (Briscoe, 2001: 8). The College of General Practitioners also labelled nurse prescribing a threat to public safety (College News 1999). The Australian Medical Association has also expressed concern about prescribing rights for nurses that has resulted in nurse practitioners with prescribing rights (58 in the state of New South Wales) being largely confined to specialised areas of hospital health care work (Cresswell 2005). The NZMA does support nurse prescribing under collaboration with doctors. It is possible to read this ‘collaboration’, in Carter’s terms, as not an attempt to exclude the dangerous ‘other’ but rather a process of colonisation whereby the “risky ‘other’ is employed to achieve ‘expert’ control of transgressions or connections between those sites defined as dangerous and those defined as safe”

(Quoted in Gabe 1995: 13). This positioning between dangerous and safe sites is evocative of the curiously legal/illegal location of the practice of rural nurses in which nurses manage the gap.

### Meeting 'need'

Carryer, Professor of Nursing at Massey University, says that “most nurses would not see this [expansion of practice] as a turf war with general practitioners (GPs), preferring instead to focus on the significant level of unmet need in the health system and the increasing difficulty of meeting that need” (Carryer, 2001: 11). In this sense nurses are positioning themselves strategically. While doctors<sup>19</sup> draw on discourses of danger and present themselves as protecting the public safety, nurses<sup>20</sup> draw on discourses of 'need', so sidestepping the polarisation and potential stalemate that may arise if the terms of the debate remained fixed in arguments from doctors saying 'you may not be safe', with nurses arguing in return, 'we are safe'. Arguing for patient 'need' also aligns nurses' aims with broad government objectives in health care policy that make appeals to the identification and meeting of patient need. But Dean (1997) would see this alignment also as a governing strategy, in so far as he argues for a concept of regulation from below.

Regulation from below represents the entry of the 'voice' of the user (patient) into the health care equation that has previously been dominated by health professionals definitions of 'need' (Dean 1997: 222). In this 'formulation 'needs' are allowed to “enter into a space of negotiated settlement conducted in the name of user rights...the agency and voice of users and carers enters into contestation with

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<sup>19</sup> I have used the word 'doctor' here as though all doctors think and act alike. While I am aware this is not the case, statements made on behalf of the New Zealand Medical Association, such as that by Briscoe are designed to be representative.

<sup>20</sup> The same qualification that I made in note 19 above equally applies to nurses.

professional practice and knowledge” (ibid). The ways that the voices of users/clients/patients have come to greater prominence has dovetailed with fear of litigation. Rose suggests that a new ‘litigious mentality’ means that the ‘shadow of the law’ “becomes a means of managing professional activity through the self- regulation of decisions and actions in relation to ...formally promulgated codes and standards” (1996:350-351). The way that the ‘shadow of the law’ regulates midwifery practice in New Zealand is discussed at length in Surtees (2003). As well the utilisation of the notion of patient need to justify the expansion and extension of nursing practice, against their construction as ‘risky subjects’ within bio-medical discourse, nurses themselves express anxieties about the extension and expansion of practice. Nurse prescribing is a case in point.

#### Ambivalences of extended practice and nurse prescribing

One nursing writer who is critical of the extension of nursing practice for the ‘wrong’ reasons is Keyzer (2001), discussing the issue with particular reference to rural nursing. He cautions against “changing nursing into some other occupational group just because doctors refuse to work in certain geographical areas”. These issues, he says, are managerial and political, not nursing problems (2001: 1). I have a fair level of discomfort with the assumption that nursing should be separate from politics and management in this way, since it can be argued that it is precisely this type of argument that has led to the relative invisibility of nursing in health policy.

Some commentators are ambivalent about nurse prescribing, arguing that rather than being nurse-led and unambiguously positive for nurses, it is rather politically driven and part of neo-liberal imperatives, the outcome of which is to commodify nursing. Nursing has traditionally had a very small role in health policy

(Lange and Cheek, 1997), although there is some evidence that this is changing in New Zealand with nurses making up part of a number of expert committees, and as advisors in the formulation of health policy (see for instance the *New Zealand Health Strategy*). It must be said however that numbers are not large. Beekman and Patterson (2003) argue that there is a risk of commodification if aspects of nursing work, such as prescribing, become task orientated. This reduction of nursing to discrete tasks leaves the way open for these “tasks to become discrete commodities to be traded within the health marketplace at lowest cost” (ibid: 16). For Beekman and Patterson, the commodification of nursing work within a health policy environment driven by cost containment represents a threat to the professionalising strategy of nursing consisting of autonomous rather than dependent practice. It is perhaps this type of critique that is behind the push to implement the new nurse practitioner role since this role has become enmeshed with the issue of prescribing.

Some rural nurses blame the slow ratification<sup>21</sup> of standing orders on the Nursing Council, and suggest that it is because they ‘sidelined’ everything else but nurse practitioner and nurse prescribing. Nurse practitioners with prescribing rights would have little use for standing orders since they would be able to prescribe the drugs they needed to use, although not all the drugs, since there are actually a limited number that nurse prescribers are able to prescribe within particular scopes of practice. Where prescribing rights would start and stop had given the following nurse pause for thought:

*I can see what they are trying to do, like with midwifery, trying to find specialist areas within nursing and the limited scope of prescribing. I see that as very beneficial in certain areas, great, marvellous, diabetes education, asthma education, neonatal intensive care. I can see that there are great*

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<sup>21</sup> It is likely that there were other reasons for the slow ratification of standing orders, but I received no response from the Ministry of Health’s Chief Advisor (Nursing) or from the New Zealand Nursing Council, when I made enquiries. The focus here, though, is on the way the slow ratification was perceived by rural nurses.

*opportunities there. But for someone like me who specialises in being a generalist where do you limit my prescribing rights. Where do you start and where do you stop? (Rural registered nurse. 2002).*

The above nurse also felt that the first step was to legalise standing orders. While the nursing hierarchy appeared to put the issue of standing orders on the back burner, it is possible to read a different interpretation. Standing orders are set rules for nurses to follow in the administration of drugs. The idea that they were set rules to follow may have been what intensified the focus on the nurse practitioner role. One of the professionalising strategies of nursing has been to position nurses as autonomous rather than dependent practitioners, hence it would appear to be outside current understandings of nursing, to habitually act on orders in that way. If instead nurses became nurse practitioners (there were none at the time my research was carried out) with prescribing rights<sup>22</sup>, the need for standing orders would be lessened. Be that as it may, the situation (without legalised standing orders) is obviously very frustrating for rural nurses:

*Legalising current practice. It's just so sensible to do it that way and standing orders would also take care of quite a bit, because standing orders will come attached with clear protocols and guidelines. This will come in and then it will take them a year to okay that. It just hasn't happened. I blame the nursing council because all of a sudden they have decided to run with Nurse Practitioner and all the rest got sidelined. They should have developed one, got it going, see that it's going and then develop the other (Rural registered nurse. 2002).*

One rural nurse was employed by the West Coast District Health Board to develop protocols for standing orders after they were ratified. She is quoted as being delighted that “regulations covering standing orders have come into force... Standing orders are

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<sup>22</sup> While there was significant interest from rural nurses in the Nurse Practitioner role, there was more ambivalence displayed about prescribing. It seems that the ideologies of those responsible for developing and promoting the nurse practitioner role and those of the rural nurses are conflictual.

wonderful for RNS [rural nurse specialists<sup>23</sup>]. Our practice outside direct medical contact can now be really safe” (O’Connor, 2003b: 21). But this same nurse expressed concern about the nurse practitioner role and prescribing rights. She felt that prescribing rights were not needed at present but really good standing orders were, arguing that the nurse practitioner role may create a division in nursing (between nurses) and foster competition between doctors and nurses where collaboration was needed (O’Connor 2003b: 21). A rural nurse cited in the New Zealand nursing journal *Kai Tiaki* says:

I think there are a lot of academic nurses having a lot of say in the direction of the profession. I think they’ve lost the plot – lost contact with clinical nursing. It is the people on the ground who really understand and I feel those academic nurses are looking down on us. I’d like to say to them come and try my job for a while (O’Connor 2003b: 17).

Although the above nurse expresses annoyance at the role of ‘academic’ nurses, a high percentage of the nurses who participated in this research were doing postgraduate papers prior to the introduction of the nurse practitioner role, thus indicating an ambivalent positioning in relation to academic work. While this research was being conducted the National Centre for Rural Health<sup>24</sup> that delivered the continuing education for rural nurses, and had done since 1998, was advised that in order to bring the current diploma up to clinical master’s level (which was a prerequisite for nurse practitioner), there would need to be new papers added. Some nurses said that they were under the impression that they had been ‘promised’ that the courses they had already done would meet the standard. While some of the nurses

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<sup>23</sup> RNS is the self-created title that one group of rural nurses in one District Health Board go by in an effort to mark the role as distinct from any other recognised nursing role. They are not Nurse Practitioners.

<sup>24</sup> The National Centre for Rural Health closed in early 2003 and other providers were sought nationally for courses for rural nurses. The Institute of Rural Health based in Hamilton has since taken over rural nurse education.

were philosophical about the lack of Nursing Council endorsement of their already completed papers, others felt severely let down:

*Now we were told at the time by the school that when you had the certificate and the diploma with all your other bits and pieces ... that we could then apply to be either nurse clinicians in our own right or nurse practitioners, now we find that we've got to do the whole thing again and they've [Nursing Council] dequalified the whole programme that we started. We were the guinea pigs that did the first programme, so we had to work bloody hard to do it, plus work full time, travel, gain scholarships, and the practice of course (Rural registered nurse 2002).*

Rural primary care nurses are positioned within these debates about the expansion and extension of practice into potentially 'risky' legal terrain in rather curious ways because their roles have, for decades, evaded tight, specialised scopes-of-practice and role boundary descriptions and so they have been caught up in different ways to their city counterparts. Codes and standards developed with city practitioners as the norm are invariably inadequate as a means of regulation of rural scopes and contexts of nursing practice. There is concern that part of the reason for the difficulty in achieving nurse practitioner status for rural nurses lies in the difficulty in articulating their scope of practice and the lack of understanding of their roles.

#### Defining scope of practice

Key to the nurse practitioner status is the need and ability to define a clear and unambiguous scope of practice on which the nurse can then be assessed, and regulated and it is this very point that has been difficult for rural nurses since their scopes and contexts of practice are very broad, crossing many inter and intra disciplinary boundaries. There was to be a 'grandparenting' clause to enable a period in which those without a clinical masters degree may be eligible to gain nurse practitioner status, in fact many nurses would argue that they have effectively been practicing at this level for decades On the strength of the grandparenting clause, one rural nurse

applied to be considered for endorsement as a nurse practitioner. The nurse reflected on the experience in the New Zealand nursing journal *Kai Tiaki* (O'Connor 2003a), of having her application for nurse practitioner declined. The nurse, with many years experience in rural health in both clinical and managerial capacities, and armed with a Diploma of Rural Health from the then National Centre for Rural Health applied and was declined, appealed the decision and was declined again. She is reported as being disappointed that no rural nurse reviewed her portfolio or was on the panel that assessed her application, indicating that she felt that her scope of practice was poorly understood by those assessing the application. Most recently (at the end of 2003) six scholarships were announced specifically for rural nurses in order to “fast track” their route to ‘nurse practitioner’.

At this point in time rural primary care nurses’ scopes of practice are assumed by the Nursing Council to be contained within the ‘primary health care’ scope of practice developed by the Nursing Council of New Zealand in consultation with nursing groups. A former co-director of the National Centre for Rural Health is concerned that the primary health care scope of practice does not encompass rural nurses’ scope and context of practice (O'Connor 2003c: 22). As has been repeatedly pointed out in the course of this thesis, the role boundary and scope of practice of rural primary care nursing in New Zealand is much more broad than that contained in any single recognised specialty scope of practice. The difficulty of simply itemising scope and context of practice is also noted by nurses themselves:

*the scope of practice is absolutely impossible to articulate to someone, the scope of your role. Absolutely impossible, you'd need four hours and that wouldn't even lick the surface. It's just so ill-defined and so broad and so vast, so general* (Rural registered nurse. 2002).

One of the tasks taken up by the National Centre for Rural Health when it was in existence was the description of the scope and context of practice of rural nurses. A number of projects were funded to this end (see Litchfield and Ross 2000; Ross et al. 2000; Ross 1996). In spite of this work rural primary care nursing work continues to be poorly understood in legislative and policy terms. Defining tight scopes of practice for the purposes of legislation and governance of professional practice is an on-going problem for rural primary care nurses.

A further new legislative framework, the Health Practitioners Competency Assurance Act (HPCA), was developed during the course of this thesis which also has at its core, tightly defined scopes of professional practice. The HPCA Act represents what Dean (1997) would call a ‘technology of performance’. Constructed as techniques of restoring trust, in this case trust in health professionals, which obviously must presuppose a culture of mistrust (Dean 1997: 220-221). The goal of technologies of performance is to “penetrate the institutional enclosures of professionals fostered under the welfare state” and to make the practice of professionals accountable, transparent and democratically controlled (ibid).

The intention of the HPCA Act is to “provide a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession” (MOH 2003:1). Part of this ‘protective’ role is to define and confine the scopes of practice within which practitioners are competent to work. The new Act covers all practitioners, not only nurses, and in September 2004 a single disciplinary tribunal was set up rather than the separate medical and nursing bodies that functioned prior. For the purposes of the HPCA Act, a:

‘scope of practice’ refers to the range of services a practitioner is competent to provide and the parameters within which such services can be offered. Such scopes of practice will cover a range of issues – including appropriate

prescribing rights for practitioners (at least, for those professions that are authorised to prescribe) (Medsafe 2002: 5).

To this end the Act enables continuing authorities, such as the Nursing Council of New Zealand, to “prepare, consult on, and gazette scopes of practice” that were to come into effect in September 2004 (MOH 2003: 1). Although the Nursing Council expressed some concern about confined scopes of practice, nurses point to the defined scopes of practice and the ‘safety’ this affords new prescribers for example. Being able to point to a discrete scope of practice and the competencies required to carry that scope out which can be demonstrated, quantified and measured (at least to some degree), moves nurses on in the debates about the ‘safety’ or ‘riskiness’ of their practice. Nurses, by rendering themselves auditable subjects (Surtees 2003), are able to consolidate a ‘safe’ health care space.

Doctors, on the other hand, are irritated by being confined to scopes of practice in ways that they have never been in the past. The introduction of the Act was strenuously opposed by the New Zealand Medical Association and the Association of Salaried Medical Specialists on the grounds that it undermines self-regulation, makes quality assurance a highly bureaucratic process, and allows for much greater levels of political interference into professional processes than before (Briscoe 2003). In spite of lobbying for the removal of scopes of practice, or failing that, for broad scopes of practice for doctors, the New Zealand Medical Association fears that as the Act stands there is a danger that scopes of practice will be more restrictive and task oriented (Briscoe, 2003).

Both nursing and medical groups are concerned about the way that the Act gives statutory regulatory authorities appointed by the government the authority to set standards of ethical conduct. Of course standards of ethical conduct have traditionally

been set by the professions themselves. Although they are arguing from very different positions, in some senses rural nurses and doctors in this instance have common needs in so far as their scopes of practice are broad and hard to confine adequately and hence render governable in the same way that the practice of an urban nurse or doctor might be.

A reminder of the complex terrain negotiated by rural nurses is encapsulated in the following quotation. When discussing the point that the issues with which rural nurses deal are similar to those that rural doctors face the nurse notes that it is in some ways harder for nurses:

*At times our actual scope is not well supported by the legislation. Although in saying that, it is an individual nurse's choice how far they push it. But all of those things have to be sorted out for us too, otherwise rural nurses will burn themselves out and there'll be less support. Probably someone's waiting for a rural nurse to do that, to actually make some quirky decision and they'll say, hey, we told you so. So that's always my extra shadow if you like, making me more aware of how careful one has to be. I think as a nurse, because you know you are actually providing a service which is never the less a nursing service, it's going to be judged by medical colleagues or the medical model. That need to be thorough is paramount in my mind (Rural registered nurse. 2002).*

The liminal space that rural nursing falls into in terms of negotiating risk is nicely put in the above quotation, where a nursing service is caught within the framework of the bio-medical model. The implication of the lack of support in legislation is one of the key factors that put some nurses off taking on more autonomous roles, as the nurse below suggests:

*I've been approached once or twice by the chairperson of the Trust, would I be interested in doing on-call instead of the GPs, or on a rota with the GPs? We're not ready for that, not legally. There's a lot of legal issues that have to be sorted out before we can do that (Semi-rural practice nurse. 2002).*

Even with the ratification of standing orders (which are unlikely to cover everything that a rural nurse might need to do), and the progress of nurse practitioners, rural nurses evade tightly defined definitions of their practice and so remain at the borders

of both legality and acceptability due to the tension that their extended roles engender in some other health care practitioners.

### **Concluding Comments**

The specificity of professional practice that is rural nursing has always escaped the bounds of what might be expected in urban nursing. Rural nursing always already exceeds the bounds of strictly controlled and confined scopes of specialised practice, and thus systems that are set up to accommodate urban needs leave rural nurses legally 'out on a limb'. As has been evident in this chapter, there is a 'remainder' in the practice of rural nursing; a lack of complete fit with systems that are predominantly designed with reference to, and set up to work in urban settings. The administration of medicines by rural nurses who work outside direct contact with doctors leaves them legally 'out on a limb'. Discourses of risk and law form core organising principles of health care practice in the contemporary western world. Rural nurses make much greater use of complexly configured discourses of trust in order to practise than do urban nurses.

The systems of trust that nurses rely on with doctors who back their practice are only as good as the level of trust between practitioners. Furthermore, the poor nature of telecommunications in some areas and the conflicting demands of providing an emergency pre-hospital care service in the form of PRIME often require nurses to function fully autonomously, at least in the first instance. While the new nurse practitioner role could potentially solve some of these issues, particularly if nurses also become prescribers, this role has been designed to accommodate very defined scopes of practice. The rigorous standards that exemplify the nurse practitioner have been much more easily identified and defined in very discrete and confined scopes of

practice, but are very much more difficult to construct around broad scopes of practice, such as that of rural primary care nursing.

The difficulty in defining scope of practice is also of relevance for the introduction of the Health Practitioners Competency Assurance bill, which again relies for its efficacy on confined scopes of practice. The areas where rural nursing escapes the bounds of urban definitions of 'safe' practice, place rural nurses in a situation where they must constantly manage potential risk, in ways that their urban counterparts in specialised nursing roles do not.

Within current debates about standing orders, nurse practitioner, and nurse prescribing, nurses can be constructed as risky professional subjects, but attempts to ameliorate this risk by specifying ever narrower scopes of practice inevitably fail in rural nursing. This failure leaves rural nurses in the 'too hard basket' when policies rely on the containment of professional practice in one way or another. Rural nurses must continue to negotiate unclear boundaries, unclear legal geographies and a lack of understanding about the breadth of their work, in the best way they know. This negotiation elucidates the tensions between policy, practice, and governance in the doing of rural primary care nursing.

The nurses who are involved in this study are willing to take the risk of working with unclear boundaries and support in legislation for their practice but this position of potential risk due to unclear boundaries creates tension and anxiety as they manage medico legal risks. There is a dearth of literature exploring the issue of gender and risk (but see Lupton 1999: 157) and there is certainly space for more research exploring the ways that nurses manage risk, bearing in mind the feminised nature of the profession. Explorations in this area could help to construct a more

detailed analysis of the compliances, contests, and resistances that nurses have in taking up or not taking up 'risky' positions.

Following on from chapter three which explored the ideological governance of nursing identities in general and rural nursing identities in particular, this chapter has looked at the ways rural primary care nurses are governed by the 'shadow of the law', utilising systems of trust. Rural primary care nursing practice though is in excess of efforts to confine scopes of practice for the purposes of making technologies of performance such as the HPCA Act 'work' in simple and uncomplicated ways. The difficulty of mapping centrally defined frameworks on to rural practice throws the discussion back to the everyday practices of rural primary care nurses in order to examine the ways that nursing practice continues to be governed in spite of the lack of fit. The following chapter represents the beginning of the next section of the thesis. This chapter takes the notion of governance to a finer spatial scale and looks specifically at the ways that nurses govern their clinical practice in relation to the doctors with whom they work (remotely).

## **Governing the Nursing Self**



## Doing Boundary work: Rural nurses, doctors, and patients

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### Introduction

The previous chapter investigated the way that the clinical practice of rural primary care nurses is extended and expanded when compared with the practice of urban nurses, so placing them at the boundary of legality. The extended and expanded practice also nudges interprofessional boundaries in ways that some doctors find disturbing. The rural area is a flexible margin, that is, a place where flexible practices make professional boundaries porous. Occupational role boundaries between medicine and nursing are much more overtly fluid in rural primary care work than is the case in urban health care, and so provide a key means of investigating the ways that practitioners understand, negotiate, contest, resist and maintain these boundaries. Practising at the edge, as these nurses do, places a much greater onus on individual nurses to negotiate, manage and indeed govern their own clinical conduct, particularly in relation to medicine and medical work. Examining how it is that nurses manage these boundaries, what I call boundary work, provides a much clearer idea of what potential exists for nurses to be positioned more widely as the first point of contact in primary health care.

This chapter examines the way that boundary work takes a particular form in rural areas due to the temporal and spatial intensity of the rural primary care nursing role. Nurses who essentially become *the* health care provider for the community,

utilise discourses of holism, in contradistinction to what are seen by nurses to be narrowly focussed biomedical discourses, to attempt to span the breadth of the roles that they carry out, and to make sense of them professionally. In undertaking these broad roles, nurses do so in ways that are more encompassing than is the case for rural doctors because, in some sense the community expects both ‘nursing’ and ‘medicine’ from rural nurses, whereas, only ‘medicine’ is expected from doctors. In the process of carrying out these encompassing roles, a particular type of surveillance space is constructed in which nurses become both subjects and objects of surveillance.

The chapter is organised into three parts. The first examines the political context in which nurses and doctors negotiate role boundaries and how nursing is positioned within these negotiations. The second addresses the rise and maintenance of medical dominance in order to better understand the ways nurses are positioned in relation to gender, profession, power, and knowledge. A discussion of autonomy picks up on this key hallmark of professional status and explores it in relation to gender and the investigates the ways that women have been positioned as ‘other’ in western philosophy which has given them/us tenuous access to ‘autonomy’. The ways that doctors and nurses play a well-scripted game is explored. The third and final section introduces the notion of holism as a sense-making tool in rural nursing. Holism is used in nursing in general as a concept that is argued to mark nursing as distinct from biomedicine but holism also has the potential to re-mark nursing as a feminine practice. The nature of the concept of holism also facilitates surveillance in health care in general, but in rural areas this surveillance shows evidence of mutuality where everyone is watching everyone due to the geographically confined nature of the rural areas. But the practise of holism also leads to an ‘othering’ of those who are non-local. The issue of surveillance becomes important in thinking about the ways in

which nursing has the potential to contribute beyond the rural as a governor of population health.

### **Investigating role boundaries**

Occupational role boundaries and professional identities, are not pre-given, but are constructed and reconstructed by practitioners working in particular historical, social, cultural, economic and political contexts. But the way that concerns are raised about role boundary crossing in the contemporary context of nursing and medicine in New Zealand serves to give the impression that role boundaries, and professional identities, are in some way fixed.

As noted in the previous chapter, the contemporary concern about the shifting role boundaries between nursing and medicine has been stimulated, in general terms, and at least in part, by the introduction of the new nursing role; the nurse practitioner, and the concern that these more highly trained nurses present a threat to medicine. Concerns about nursing encroaching on the field of medicine have been especially marked at the interface between nurses and GPs. Within medicine itself, general practice has enjoyed falling popularity as a medical area of choice for doctors (Dowell et al. 2002; Hill et al. 2002; The Dominion 1999), and, as well as this, concerns are frequently voiced about what is perceived to be a growing crisis and increasing shortage of rural GPs (Hays et al. 1997; London 2002; The Dominion 2000; The Evening Standard 2002). Particularly in rural areas, where the viability of general practice is sometimes marginal, some doctors are concerned that nurses want to take over 'their' jobs. At the same time as doctors are unwilling to work in rural areas, they are unwilling to see nurses occupy these positions.

Boundary disputes between medicine and nursing are not a new concern. In the early days of general practice in New Zealand, in rural areas doctors were concerned that the newly introduced district nurses would affect the profitability of their practices. McKegg (1991) notes that this was the case both in Britain and New Zealand. Valentine (the then Chief Health Officer) was at pains to point out that “in no sense of the word would the district nurse be expected to ... in any way take the place of the general medical practitioner” (AJHR 1909, H-22: 6). By 1911 Valentine was to say:

The success of the district nurse in this country is assured – especially where the medical men of the district are in sympathy with the movement, which is sure to be the case, provided the district nurse adheres to the rules laid down, and does not attempt to usurp the functions of the medical practitioner (AJHR 1911, H-31: 8).

In some cases the doctors in this early period were concerned that the nurses were keeping the patients in too good a health for their practices and were diagnosing and treating things that the doctors thought should be under their care (McKegg 1991: 37-38). Hence, rural areas have long presented a challenge to expected and taken for granted occupational role boundaries in the health care arena. Contemporary practitioners tensely negotiate these role boundaries.

At the 2002 Combined Rural GP, Rural Nurse conference there were concerns expressed about nurses increasing their roles and taking over rural doctors’ jobs. In the face of a crisis of recruitment and retention of rural general practitioners, this appears to be simply deflecting blame<sup>25</sup>. This is a point picked up on by Carryer, who states that while there will be overlaps in the training of nurse practitioners and general practitioners, this should actually prove to be “useful, given the increasing shortage of GPs in remote communities and in poorer socio-economic areas” (2001:

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<sup>25</sup> It should be noted that there are well funded initiatives currently in place to attempt to turn the tide on recruitment and retention of rural GPs. These are having mixed success.

11). Nurses, it seems, refuse to be located as the reason for the shortage of rural doctors. As Carryer states the shortage exists and nurses may be able to meet some of that ‘unmet need’. Nurses argue that they can deliver more cost effective services than doctors, while doctors argue that there is in fact no difference in cost.

Although not speaking solely about rural nursing, Carryer et al. (1999) indicate that nursing as a discipline is well prepared for the increasing emphasis the Government wishes to see given to illness prevention and health promotion. Indeed, Carryer et al. argue that nurses, for the last twenty years, have been trained to meet this model, but have not had this ability recognised. Nurses are represented in the above publication, *Locating Nursing in Primary Health Care*, as being situated within a site of “tension between what nursing is in its theoretical intent and focus and what it has become due to patterns of utilisation” (Carryer et al. 1999: 8). The authors state that:

Philosophically, the values embodied in nursing are about the enabling of human potential in a wide range of contexts. This approach seeks to foster optimum health in individuals and communities and is mindful of the particular challenges and impediments that may be present. These values are broader than the curative aspects of health. They include the notion of other influences like social policy, education, unemployment, ethnicity and community culture. The underlying characteristics are social justice and equity, international solidarity, self-responsibility and an acceptance of a broad concept of health (1999:8).

In 1998, the then Minister of Health, Bill English, established a taskforce on nursing. The *Report of the Ministerial Taskforce on Nursing: Releasing the Potential of Nursing* was the first review of nursing for more than fifteen years. This document can be seen to ‘set the scene’ so to speak for the more extensive utilisation of nurses, and the extension of nursing practice. In his foreword to the report English notes that the taskforce was:

Established in response to calls from nurses and nursing organisations who had been telling me that there were obstacles to the nursing profession

realising its full potential with respect to health service delivery. I thought it was important to make sure that the health sector effectively uses what nurses have to offer. I believe that there can be a much *smarter* utilisation of nursing skills. The nursing profession needs to continue to adapt to meet the challenge of radically changing delivery of health care (1998: 3. Italics mine).

In 1999, another government-sponsored report indicated that:

Capitation funding can encourage more efficient use of health resources, particularly the skills and knowledge of nurses. There is scope for a much expanded role for primary care nurses in chronic disease management, community liaison and as interdependent members of the primary care team (Coster and Gribben 1999: 2).

These two quotations argue for the *utility* of using nurses in expanded or extended roles. On one level it can be argued that there is a good correlation between what nursing groups and government health policy, particularly in its articulation of neo-liberal principles, want. Some caution should be exercised here in that nurses are cheaper to pay than doctors, and so a degree of doctor/nurse substitution may suit those concerned with health care cost containment very well, regardless of professional issues and boundaries. The outcomes though, will depend where the power to decide who does what resides. Keyzer, who held the Chair of Nursing (Rural and Remote) at the University of Sydney, is concerned in this regard. He suggests that there is a difference between expanded and extended roles in nursing. He sees distinct roles for doctors and nurses and argues that nurses and nursing should tread carefully in terms of role change. He insists that:

The difficulties of attracting doctors to the rural and remote areas are a managerial and political problem. It is not a nursing problem and we should not allow ourselves to be manipulated into changing nursing into some other occupational group just because doctors refuse to work in certain geographical areas (2001: 3).

There are several problems with this caution, such as the fact that a number of nurses in rural areas are very keen to take on a formally expanded role that, in many ways, only sanctions what they have been doing anyway. But, Keyzer is right to advise

caution, since what is strategic for government is not always in the best interests of rural nursing, medicine, or for that matter, patients.

### **The rise of medical dominance**

Chapter one highlighted the ways that nursing has played a key role in rural and remote health care since the earliest days of New Zealand settlement. What is perceived, in the media for instance, to be a contemporary crisis in rural health care provision, appears to be more a variation on a longstanding theme, rather than some new entity. In order to understand the relative positioning of medicine and nursing in relation to role boundaries, it is important to look at the rise of medical dominance.

From these earliest days, the interface between medicine, nursing and other occupational groupings in the health arena, has been contested. In the latter half of the nineteenth century, for instance, doctors, dentists, chemists and midwives intermingled in “the volatile jumble of nineteenth century work” (Belgrave 1991: 7). Towards the end of the nineteenth century and the early part of the twentieth century, this “volatile jumble” began to take a more recognisable form, by contemporary standards.

The period between the wars saw the consolidation of the position of medicine in New Zealand. In the medical division of labour, as medicine gained dominance, other related occupations were either confined to narrow spheres of practice, as in the case of dentists for example. Others, such as chiropractors, were marginalized, while nurses and pharmacists, were subordinated and only able to practice with the authorisation of doctors (Belgrave 1991; Freidson 2001). Freidson argues that:

Professionalism may be said to exist when an organized occupation gains the power to determine who is qualified to perform a defined set of tasks, to prevent all others from performing that work, and to control the criteria by which to evaluate performance (2001: 12).

The gaining of control over medical work, by determining who was qualified to perform certain tasks, led to medicine coming to claim status as a profession.

One of the ways that the professions define their scope is by reference to a particular body of knowledge that requires discretionary judgement and a grounding in abstract theory and concepts (Freidson 2001). The contestation over where the jurisdictions of nursing and medicine lies has been an extremely important part of the way that the professional identities of both medicine and nursing have developed, and the ways that their professionalisation strategies have played out. To avoid routinization (and the danger of external control that this allows), professional knowledge has needed to claim a level of indeterminacy, a “distinctive mystique which suggests that there is a certain professional attitude and competence which cannot be reduced merely to systematic and routinized knowledge” (Turner 1995: 132).

In the case of medicine a large part of the authority commanded rested on the possession of scientific knowledge. Building on the enlightenment faith in objective science and reason, rationality, and the inevitability of ‘progress’, scientific medicine seemed to offer control over pain, suffering and disease. With the development of anaesthesia, antibiotics, insulin and chemotherapy during the twentieth century, these hopes appeared to be well founded (Pringle 1998). The prototypical profession is scientific in character (Davies 1996; Freidson 2001). But, interestingly, Friedson, following Rueschmeyer (1964), points out that the profession of law maintains a strong professional status in spite of having no base in scientific thinking (2001: 154).

Since the 1970s, medicine has not enjoyed quite the status it had previously and, although medical discoveries continue, Konner (1993: 49) suggests that we have been lulled into a false sense of security where we have come to think that anything

that is broken can be fixed and “anything that is wrong with us has its own private molecular magic wand that, when waved over us, will make it go away”. Konner (1993) advocates that people should withdraw the godlike expectations they have of doctors and take more responsibility for their own health. Taking more responsibility for our own health is also, of course, part of the current neo-liberal governmental ethos. But while the age of ‘heroic medicine’ may be over, to be replaced by the mundane medical management of chronic as opposed to acute illness (Turner 1995: 8), medicine remains a powerful player in the health care arena.

Medical work is not uniformly prestigious. Generalist medical work, like generalist nursing work, can tend to become marginalized, and is often poorly understood in a climate of increasing specialisation. Depth rather than breadth has come to be valued in medicine, which has given rise to specialisations<sup>26</sup>, and “specialists, with their ‘command’ of an area are more highly regarded than generalists” (Davies 1996: 666). Furthermore, bounded work, such as that which is practised in a speciality, is more easily defined and defended (ibid). In this sense then, GPs become the ‘subalterns’ of medicine (Pringle 1998). General practitioners are the medical practitioners with whom rural and remote nurses engage, and whose roles they are assumed to be contesting. Pringle highlights the importance of general practitioners as a type of biomedical boundary police:

[t]he positioning of GPs on the boundaries is also not without strategic possibilities. Since they are the ones who come into most regular contact with the general public, they contribute a great deal to the reputation of the medical field as a whole. And, since the task of defending the boundaries of the field also falls to them, they have choices about when to repel invaders and when to cooperate with them in ways that might reconfigure the whole field (1998: 157)

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<sup>26</sup> It must be noted that the medical workforce in New Zealand is not as highly specialised as it is in some countries, the United States for instance.

Within nursing, specialised areas have also become privileged. The privileging of specialised areas has been drawn as part of the professionalisation project in nursing. Thornley (1996: 173), following Clay, says that the professional model in nursing “usually draws on the more technical field of acute care to argue that nursing requires a ‘certain level of intelligence, skill and knowledge’ and can no longer be compared to nursing of the past”. An alliance with the technical field of acute care, while strategically useful in the professionalisation project, also serves to valorise specialist over generalist work and high-tech over low-tech work.

Those occupations that historically, came to accept a subordinate role in relation to medicine, did so in order to gain a place in the developing medical economy, with often both the models of work, and professional aspirations, being based around those of medicine (Belgrave 1991). In the face of the dominance of medicine, groups such as nurses who were subordinated were called ‘semi-professions’ or ‘lower order’ professions (Abbott and Wallace 1990; Etzioni 1969). The term semi-professions means new professions whose claim to the status of doctors and lawyers is not fully established in that “their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge” (Etzioni 1969: V). But, further, Etzioni suggests that these semi-professions may not desire profession status. Indeed, the professionalisation project in nursing has been marked by ambivalence, with some commentators asking why nursing would want to become a profession given the masculinity of the professional model. The semi-professions were also argued to have “less autonomy from supervision or societal control than ‘the’ professions” (Etzioni 1969: v). The notion of autonomy is at the core of both cultural concepts of masculinity and profession (Davies 1996).

## Autonomy, gender and the invisible/visible nurse

The concept of autonomy has a long history in philosophy, and, in common-sense terms, means “the self-rule of individuals, of groups, and of states” (Griffiths 1995: 135). A reading that promotes modernity as a “revolt against the tyranny of authority” where the modern individual is “assumed to be an autonomous male, free of familial and communal ties” (Felski 1995: 2), begs the question as to the gender of autonomy. For philosophers such as Kant, autonomy was seen as acting rationally in the pursuit of one’s self-chosen goals. Because mature reason had to be developed in the public sphere, a space traditionally dedicated to males, within Western philosophy women have been, at least implicitly, excluded from full autonomy (Griffiths 1995: 135).

Many feminist analysts of the professions suggest that the very construction of the notion of profession is inherently masculine (Davies 1995a). Within the terms of enlightenment thinking, that are grounded in dualistic frameworks, this latter claim is hardly surprising. Dualist or binary modes of thought are part of the terms and conditions of modernity, hence women are often implicitly located outside of modernity as its ‘other’ (Morris 1988; Felski 1995; Pringle 1998).

Part of the potential to ‘other’ women is the association that women have with the body. In dualistic terms, the duo masculinity/mind is set against femininity/body. There is not only a separation between masculinity and femininity, mind and body, and a hierarchical relation where the masculine is privileged over the feminine, but there is also a dependency relationship. Thus, Longhurst (2001), following Rose says that in order to establish the notion of rationality, a contrasting concept; that of irrationality is necessary to consolidate the meaning of the former term. In a dualist logic irrationality and the body are located on the same side of the dualism (Longhurst 2001: 13). This ‘othering’ obviously has implications for feminised occupations.

Perhaps the unconscious of health care involves a gendered conception of the doctor as mind and reason, and the nurse as body and emotion.

Associations with embodiment have historically been very overt in nursing and there is no denying that nurses do ‘body work’. This body work is also boundary work but of a different order than that which nurses negotiate between themselves and doctors. Traditionally much of the body work in nursing was delegated to more junior staff, but with the demise of task-based nursing to versions of total patient care this delegation no longer occurs. Total patient care involves each nurse being responsible for all of their patients’ needs on any given nursing shift. Nurses, as “socially appointed *agents* of abjection” (McClintock 1995: 72) take care of bodies and deal with the abject. The abject in this sense refers to bodily substances such as tears, saliva, faeces, urine, vomit, mucus, blood and pus (McClintock 1995), as well as dead bodies (Lawler 1991). These are substances and states that have a tendency to inspire disgust and revulsion in Western culture and which doctors, to some extent can distance themselves from, since nursing is marked by the proximal nature of its practice. Nurses do many other things as well as dealing with the abject, but they risk becoming over-determined by this connection, prompting some nurses to attempt to distance themselves from body care, though they cannot escape embodiment. Lawler (1991) argues that the practice of ‘body care’ has been hidden, taken for granted and not regarded as formal knowledge, partly because there has been no descriptive language for this work. Part of the lack of language is to do with conflation of nursing and mothering, inherent in which is the notion of the ‘naturalness’ of these practices.

The English language does not make a distinction between nursing babies and nursing the sick (Devereux and Weiner 1950). In the period 1860-1930, which covered the development of nursing as a “distinctive secular occupation for unmarried

women” (Turner 1995: 144), nursing and mothering were conflated. A number of commentators have suggested that this conflation of nursing with mothering is a key facilitator of the dominance of medicine over nursing, since mapping nursing on to models of the patriarchal family, in which the woman was subordinate, merely meant these uneven relations were replicated in the arena of healthcare (Gamarnikow 1978). Within binary structures, women are represented as more traditional, closer to nature, limited by and to their/our bodies. Although, feminist critics have argued for the need to deconstruct binary or dualistic categories that lie at the base of modernist thinking, the structure remains pervasive and within its terms, and at this philosophical level, nursing can be argued to be medicine’s ‘other’, the feminine to medicine’s masculine.

Autonomy is part of the enlightenment project, and also part of the professionalising strategies of nursing. It is the calls for increasing autonomy in nursing work that present problems for some doctors. Davies (1996: 666) argues that the “professions can represent themselves as autonomous only by ignoring or misrepresenting the work of others” (see also Tronto 2001). In a complex twist, bureaucratic organisations, such as health care rely upon feminised work at the same time as they deny it (Pringle 1989; Davies 1996). Understanding this simultaneous reliance on, and denial of feminised work helps in understanding why nursing has had such trouble articulating a language that describes its work. Making nursing knowledge overt in language undermines the denial necessary to maintain the perception of autonomy that biomedicine trades on.

In a now famous paper, American psychiatrist Leonard Stein (1967) identified what he called the doctor-nurse game. Stein suggested that the relationship between medicine and nursing was one where, in a simultaneous acknowledgement and denial of nursing expertise, medical and masculine authority was confirmed. But this

medical omnipotence was not simply imposed; it required the active cooperation of the nurses (Pringle 1998: 190). Far from being a theoretical formulation with no empirical basis, the doctor-nurse game has been very obviously played out, as a recent example illustrates.

In early 2004 at a conference of rural nurses and rural doctors I was at a presentation about the changes in the Accident Compensation Corporation that were of relevance for rural contracting. The doctor (employee of ACC) that gave the presentation was talking about the great respect he had for nurses. He said he would always remember a sister at a hospital he worked at early in his career. When working in the fracture clinic this doctor learned to pay attention to a particular throat clearing exercise that the sister did to indicate that she could see a fracture on the x-ray whilst the doctor could not. By covert methods of communication the nurse diagnosed fractures, but allowed the doctor to think that he had identified them. This elaborate and inefficient ruse allows the doctor to maintain 'face' and the appearance of expertise, while the patient benefits insofar as a diagnosis is achieved and acted upon. The nurse in this process is necessary but invisible. This is a very good example of the unacknowledged place of 'others' in producing a sense of the autonomy of medicine.

The absurdity of the ruse of the doctor-nurse game is striking. What prevented the above nurse from saying directly that she could see a fracture on the x-ray? Stein concluded that nurses, the majority of whom had been trained in hospital schools of nursing, had been taught that making suggestions to physicians was equivalent to insulting or belittling them, questioning their medical knowledge or suggesting that they did not know their business. By 1990, when Stein et al. revisited the doctor-nurse game, they found some shifts in thinking that indicated nurses were less willing to

“play the game”<sup>27</sup>. Part of this shift can be attributed to the move of nursing education out of hospitals and into universities and polytechnics, where there is little if any overt medical influence. Nurses have become more willing to challenge doctors directly on issues such as drug dosages, wound healing and palliative care (Wicks, 1993). But, Davies (2003) suggests that uneven relations persist in contemporary health care between doctors and nurses in a constructed form that she calls ‘doing dominance and doing deference’. In many senses the doctor-nurse game has little utility in rural health care due to the lack of proximity between doctors and nurses, but the conditions that lead to the cultural construction of the doctor-nurse game are inescapable insofar as doctors remain the gatekeepers of medications and admission to hospital at least.

In spite of the awareness of the doctor-nurse game, the development of the relations between nursing and medicine has been framed around gaining and maintaining control over aspects of health work and are therefore played out spatially. Traditionally, it has been the role of doctors to diagnose while nurses carry out treatment (Walby et al. 1994). Nurses were carers and doctors those who cured illness and disease, as Porter says:

One of the fundamental bases of [medical] dominance is doctor’s control over diagnosis. For any health problem, action stems from diagnosis, and because of this the diagnostician will assume an authoritative role in his/her relationships with clients and allied occupations (1995: 42).

It is debatable if ‘care’ and ‘treatment’ can actually be clearly distinguished (Walby et al. 1994), although some nurses try to maintain the distinction as a means of making sense of how they are positioned within their work. With regard to the extension of practice into formal prescribing the following nurse is not interested in taking up the

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<sup>27</sup> Thanks to Julie Cupples for pointing out the continuing nature of the ‘doctor-nurse game’ in popular television dramas such as ER.

option, even though the nurse prescribes anyway. This highlights the contradictory nature of the position assumed by the nurse. The nurse makes a clear distinction between care and cure:

*I will not choose to do prescribing. I think prescribing is such a broad area. I am interested in being a nurse. I am not interested in being a mini-doctor and I see nurses as the caring nurturers. I see doctors as the curative and I don't want the status of being able to prescribe. I think that there are may be responsibilities that go with that that I don't like, but I also see that I want to advance nursing and I don't necessarily feel that I need to be curative to advance the caring and the nursing that I do. Saying that, I do a lot of prescribing illegally because I have a doctor who is very trusting of his nurses and I know he would support us to the hilt (Rural registered nurse 2003).*

When practising nurses are required to “diagnose and treat”, that is to act in autonomous ways, when it suits others, as in the case of the nurse above. The arbitrary nature of these boundaries is also evident in different types of nursing. Arminee Kazanjian notes that:

[n]urses cannot diagnose, prescribe or initiate technical procedures. It is somewhat paradoxical, however, that during the night shift these restrictions are somehow lifted (although only implicitly), and the nurse on duty shoulders enormous patient responsibilities. In nursing circles this phenomenon is jestingly referred to as ‘the reverse Cinderella syndrome’. (1993: 158).

Restrictions to autonomous practice are, seemingly, flexibly applied at the margins, that is; on night duty and in rural areas. Although very few nurses today would consider themselves ‘handmaidens’ of doctors, consistent autonomy is not easily won in current nursing work. Perhaps the notion of autonomy itself is slippery and contingent. Traynor suggests that it is important to recognise that nurses may well construct their own version of autonomy as a competing rationality in the provision of health care (1999).

#### Playing doctors and nurses

In clinical terms, tensions surrounding the appropriate jurisdictions of nursing are more often evident in interactions with doctors other than the GPs that nurses work

loosely with. This lack of tension with the doctors that nurses regularly work with is, according to several of the nurses, largely due to the fact that both doctors and nurses are employees of the regional health board rather than the owners of private general practices. Therefore, they are not in competition for patients as they may be in a private practice.

Other nurses can also prove obstructive by policing boundaries they perceive have been inappropriately breached:

*Often you'd ring to get a patient admitted and you'd get someone that didn't know the area and they wouldn't admit your patient because you were a nurse.... One patient I wanted to admit, I rang for a surgeon and he was in theatre and I got the nurse. [the nurse said], has the patient been seen by a doctor? [I said], no, I am the nurse at this area, I want to admit this patient because of such and such. Where is the nearest doctor? Forty five minutes in the opposite direction and I'm not sending him up there. Will he be seen by a doctor? No, he won't be seen by a doctor, because I'm the nurse on call and I want to admit him. This went on and on, and I said, I need to speak to a doctor now. She finally got him and I told him what was going on, send him down he said (Rural registered nurse 2002).*

It is more common though for nurses to get the 'twenty questions' from doctors, and then not *all* doctors. The tension with 'other' doctors is most often encountered when nurses want to admit patients to hospital. Doctors are, most commonly, the gatekeepers of who may be admitted to hospital, and for some, having to engage with a nurse is challenging:

*Even registrars, because you are only a nurse, ...they won't believe you, they don't trust our assessments (Rural registered nurse. 2002).*

The above nurse is caught between acting autonomously and providing appropriate patient care and the need to convince another health professional that the nurse is 'authorised' to make judgements about that care. Similarly, the following nurse's authority is called into question:

*I've only had one young doctor in A&E and he really gave me the twenty questions on why were nurses doing the on-call, how long are you going to do it for, can we expect this all the time sort of thing and yeah, he was quite rude*

*really, but he's the only one, everyone else has been fantastic* (Rural registered nurse. 2003).

When nurses ring hospitals for advice about patients, they sometimes experience antagonism or simply ignorance of the situations in which the nurses are working. The following nurse seems to be constructed as out-of-place in a conversation with a surgeon; as not a 'natural' partner in a conversation about the potential need for surgery that a rural patient may have:

*You've got the arrogance of some surgeons who think that nurses shouldn't even be talking to them on the phone, and I've had them actually say to me and I just laugh in their face* (Rural registered nurse. 2002).

A nurse can also be conceived of as a 'stop-gap', rather than a fully functioning health care provider attempting to access tertiary care for a patient, by some hospital staff.

*But that constant ... well when's the GP coming ... I'm sorry we don't have a GP, this is a nurse-led service and I've made an assessment and I'd like to send this patient down and I guess it's only through gaining that experience and dealings with rural nurses, that other health professionals are going to see what we are capable of doing but we are also at that horrible point where there'd be people who'd be glad to see us make a mistake and be pulled down* (Rural registered nurse. 2002).

This nurse's final comment about being at a horrible point where there are people who'd be glad to see us make a mistake is quite telling. This comment indicates that some nurses are fully aware that there are those who see them as working beyond their expertise and who are waiting for 'something to go wrong'.

One nurse indicated that the tables could be turned, insofar as doctors could be seen to be working for the nurses rather than the other way around, but this stance is softened to suggest that they all actually work in a team:

*People ask us if we have doctors that work here at the clinic, and I say no, but we have doctors that work for us. Some people look at me and laugh and think that's arrogant, but it's just a fact, they come [here] ... what do you want us to do ... we're here for the day what can we do for you? We have one a month, they come and tidy up the stuff that we can't. It's usually things like medicals and difficult smears that we can't manage and referrals we're not sure of, or someone we want a second opinion on, and these guys we're in contact with*

*during the week anyway, we work as a team. They will talk to us any time at their surgeries, even if they have their own patients, they will still talk to us* (Rural registered nurse. 2002).

The episodic, rather than encompassing nature of ‘trouble with doctors’ is highlighted in the following transcript:

*My personal experience with doctors is that most of them are pretty accepting of your practice and are encouraging, you know, especially the doctors that work here. I mean the only time that I have ever sat there with my mouth open was [with] a young doctor that was over here just for the experience in rural practise. I think he was a house surgeon, he has just kind of graduated, or was in his last year or something and his attitude was well, you know, he didn't agree with nurse practitioners really, blah, blah. That blew me away because I thought the more modern doctors, the younger ones sort of going through now would be more open but no, maybe it's the older ones that aren't so threatened by it, that have learned to be much more open minded and accepting* (Rural registered nurse. 2003)

In the context of the sometimes uncomfortable positioning as ‘out of place’ in the often solo provision of primary health care, nurses draw on the discourse of holism to attempt to make sense of their uneasy position between nursing and medicine.

### **Holism as a language of nursing**

Both general practitioners and nurses have drawn on discourses of holism to assert a particular position in the health care division of labour. While nurses needed to establish their jurisdiction, so did GPs. In order to distinguish themselves from hospital specialists GPs needed a distinct body of knowledge to avoid the redrawing of boundaries and their exclusion from the medical field entirely (Pringle 1998: 160).

The emphasis on holistic medicine has served general practice well in its struggle to differentiate itself from the specialists but it has problematised its place in the medical field with the extreme emphasis on specialisation. Furthermore the interpretation that nurses and doctors would have of holistic care differs insofar as general practitioners in private practice usually spend severely limited amounts of time with patients, while

there is at least the potential for nurses to spend more time. Part of the process of sense-making for rural primary care nurses is exhibited in their use of the idea of 'holism'. Rural nurses, and to a lesser extent rural doctors, practise holism in a very encompassing way as will be explored later in the chapter.

Oppressed groups frequently develop their own discourses that work in contradiction to dominant ones (Moore 1994). Deciding on differences, in this way, is one way of marking out identity, and forming, and maintaining group boundaries (ibid). Nursing has had trouble identifying a specific body of knowledge and skills that 'belong' to it (Abbott and Wallace 1990), and thereby asserting this 'difference'. The claim to control a specific body of knowledge, and autonomy in the practical application of that body of knowledge, are key features of a claim to professional status. One of the arguments that has been advanced by nurses as they strive to identify a body of knowledge over which they have jurisdiction, is that doctors are narrowly focused on illness. By contrast nurses are interested in more than that.

Lawler explains the difference thus:

The medical model, while it deals overtly with the body, does so in a way that is reductionist and deterministic, and it stresses relationships of cause and effect. It is a model which is fundamentally mechanistic. Nursing practice, however, is more interactive, more social, and more holistic. One cannot simply nurse the body in the bed. One must do business with it as a person because nursing means being able to view the body and the person as inseparable (1991: 34).

The concept of holism involves considering all aspects of the person; social, biological, medical, pathological, spiritual, psychological and so on (Lawler 1991) and in so doing also taking into account the provision of health education, disease prevention and assisting patients and families to cope with chronic illness. The move from task based nursing towards total patient care shifted the focus from the task at hand to the more holistic view of the patient as an individual. Thus, it is often this

broader, more holistic discourse that is used to set nursing apart from the narrowly focused biomedical approach to patients (Boschma 1997). The medical model or the traditional biomedical approach presupposes a clear mind/body distinction<sup>28</sup>, whereby in a reductionist logic, all disease and illness would be able to be explained sooner or later by some biochemical change, or mechanism. The biomedical model is also exclusionary in that alternative models are marginalized or excluded as ‘invalid’ (Turner 1995: 9-10).

The process of claiming holism is not ‘innocent’. Traynor argues that while the nursing profession is “able to critique effectively the medical institution as engaged in a process of maintaining a significant power base, marshalling biomedical knowledge as one of its resources” but in the process of doing this, nurses seem to take at face value their own rhetoric of “holism, patient advocacy, professionalism or feminism, unwilling to understand those arguments and rhetorics as cultural resources, discourses that are adopted to further the profession’s desire for power” (1999:63). The differential power relations between the biomedical and holistic discourses must, however, be acknowledged, and at least some of this differential may be attributed, in the light of the binary thinking mentioned earlier, to gendering.

Boschma states that the focus on the psychosocial serves to provide holism with a gender bias:

The paradoxical nature of holistic patient-centered care concepts was that their description still resonated with the older idea of nursing as a higher female calling ...when it was the nurse’s female characteristics in particular that made her fitted for the job (1997: 172).

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<sup>28</sup> There are parts of medicine that are moving away from subscribing to purely biomedical interpretations of illness and disease. For example, the management of chronic pain often involves a broad range of practitioners such as physiotherapists, occupational therapists, psychiatrists, psychologists, nurses and anaesthetists in an effort to address the complexity of the management of an individual’s chronic pain. There are struggles for authority within these teams of practitioners who come from different paradigms (Alchin 2003 *pers. comm.*)

In much the same way as appeals to holistic care placed GPs in a marginal position in relation to those doctors practising in highly specialised hospital medicine, holism can at one level be argued to re-invent turn of the (twentieth) century notions of nursing as ideally fitted to women. But, rather than dismiss holism as an irredeemably gendered concept with no purchase, it is rather more useful to tease out what utility it has for rural nurses.

While many nurses utilise the idea of holism, it has a different significance in rural primary care, helping to span the breadth of the work that the nurses do, without having to compromise the title 'nurse'. In the context of discussing the enormous breadth of the rural/remote nursing role, a role spanning cleaning and roadside resuscitation, I asked one nurse: Is it nursing?

*What I do? Yeah, I think it is. I've struggled with that long and hard and I think initially I got scared that a lot of the advanced skills and techniques that I had taken on board were medical. That felt all right and I did feel sort of that my mana had increased, but I'm a nurse because that's my paradigm...I'm not sure myself what is nursing other than it's advocacy for the patient to have the best quality of health. To give them the best ... they've all got potential and I guess it's to help them live that potential. And it's to give people respect and time and understanding and empathy and not just technical bits and pieces...(Rural registered nurse. 2002).*

There is acknowledgement in the above quotation about the potential that taking on parts of practice that had previously been the preserve of medicine has to enhance mana (prestige) for the nurse, but this is qualified immediately with '*but I'm a nurse because that's my paradigm*'. The way that this nurse explains what nursing is, draws on the notion of what patients 'need' (even if not directly stated) to make sense of the extended role that is provided in the area in which the nurse works. Similarly, in the following quotation, the nurse rejects what is done in the context of the role as being medical, by defining the role as 'health practitioner'. This acknowledges the way the

role escapes conventional boundaries around nursing, but the nurse does not accept the designation of mini-doctor:

*You know I've heard another nurse say, if you want to be a doctor, if you want to be a mini doctor why don't you just go to med. school? You know, the impression is that that's what we're being. I'm being a health practitioner (Rural registered nurse. 2002).*

Similar arguments have been advanced in the United Kingdom surrounding the medical-nursing boundary. These debates reached a high point in the early 1990s when discussions were conducted about how much 'more' nursing could do in the face of the need to curb junior doctors' hours in hospitals. Nurses' roles did expand and a furore about nurses becoming mini-doctors ensued (Allen 2001: 126). There seems to be some degree of resignation now to the shift in the medical-nursing boundary, with more concern being expressed now about the ways that these expanded and extended roles for nurses will be regulated and standards safeguarded (Allen 2001).

Nurses, to construct nursing as something more than medicine, deploy the concept of holism. Being careful not to claim that she does the 'doctor' role, although a doctor in an urban environment would see many of the things that this nurse sees and the nurse is required in the course of any day's work to diagnose:

*Well look, not that I see myself in a doctor role because I don't, because it's a totally different role. I've had people say to me, look why don't you just finish off and do your doctor's training? I honestly feel as a nurse I can offer more because I have the privilege of the job I'm in I can see people, I can see them in their home. I can follow up. I can offer more advice and support whereas a doctor gets that 10-15 minute window to deal with whatever. So I mean it's a much more holistic service (Rural registered nurse. 2002).*

The in-between professional space occupied by these nurses is also clearly articulated in the following quotation:

*Nurses do bring a bit more too; we bring a bit less, but we also bring a bit more (Rural registered nurse. 2003)*

The notion that nursing offers more, particularly in the rural environment, is also clear in the following quotation that locates the nurse as someone who can do all of their own role and some of what is usually perceived to be the doctor's role. The overlap between 'nursing' and 'doctoring' is evident. But, this nurse constructs nursing as the flexible occupation that spills over the boundary and is able to take on 'some of the doctor's role', while doctors are 'incapable' of 'doing a nurse's role':

*A doctor is incapable of doing a nurse's role; nurses are capable of doing some of the doctor's role (Rural registered nurse. 2002).*

Two nurses were both present at a particularly 'messy' death at home where there were body fluids that needed to be cleaned up, as well as supporting the relatives that were present, and arranging for the undertaker to be called in. The two nurses speculated about how the situation might have been dealt with by the doctor that they worked with:

*Nurse one: The other thing we thought about that scene is that if [the doctor] had've been there, how much more traumatic that would have been for family members. Imagine [the doctor] cleaning up...*

*Nurse two: Because what [nurse one] did while I was doing my bit, was that she cleaned everything, washed the walls down, she did the washing and everything and so we left it really well didn't we?*

While I doubt that any registered nurse has 'cleaning' as part of their job description at this point in time, these two nurses thought that one of the most helpful things to do for the family was to restore some sense of order to their environment by 'cleaning up', and they could not imagine the doctor doing this. This example also provides a concrete playing out of the notion of nurses as socially mandated agents of abjection. The nurses restored order by 'containing' the abject substances; everything was restored to its proper place. The nurses were both willing and able to spend more time with the patient's relatives after the death and clean up.

The tension between holistic care and boundary work: Nurses and patients

The purpose here is to focus solely on the deployment of holistic care and the implications that has for boundary work in the form of co-surveillance between nurses and patients. In many ways holism seems to be an imperative in the rural community. The following nurse indicates a shift in community thinking that serves to construct the nurse as an ‘appropriate’ practitioner as the first point of contact to the health care system, while also indicating the ‘difference’ in the nurses’ practice which the nurse perceives to be encompassing (holistic), proximate and continuous:

*They are starting to understand. Often they are asking for us before they are asking for the doctor too. Which is interesting, so we are actually dealing with them holistically, because you’re here every day, so keeping the continuity up. We’re the ones getting back to the doctors and suggesting this and wanting advice on that (Rural registered nurse. 2002).*

While health care is sometimes seen as an approximation of Bentham’s panopticon (Foucault 1977), rural health care is much more a type of mutual surveillance than the one-way surveillance that the panopticon promotes. Perhaps the type of surveillance is more akin to that “structured not as the Panopticon but as the Abbey of Theleme so picturesquely described by Rabelais – where everybody watched everybody” (Khakordin 1995: 214 cited in Thrift 2000: 275).

While many patients much prefer to be treated like a whole person, paying attention to physical, spiritual and psychological ‘needs’ and not as a case or a condition, as can sometimes happen in large busy hospitals, there is also a tension inherent in the level of knowledge required to provide holistic care. In a city, the encounter with the health care provider is controlled to some degree by the patient, at least for routine and chronic health care. It is relatively unusual to meet up with the people who provide you with health care in the community. Whereas, in the rural

area, health care providers, in this case nurses, are frequently visible. The very embodied presence of the nurse becomes a reminder.

It is perhaps this rural remote nursing role that is actually equipped to deliver holistic care in its most complete form. With the current trend for short hospital stays, it is questionable to what degree the trio of physical, spiritual, and psychological aspects of patient needs, can actually be addressed in urban practice. In rural areas it is possible to have knowledge about people that makes the provision of holistic care more possible and more likely to occur. Of course, it must always be remembered that the physical part of holism, in the case of rural and remote area nurses encompasses a much wider brief than in the urban environment, and this extension of practice opens the way for an ambiguous positioning.

One of the group interviews conducted for this research involved a group of nurses who had recently taken on the on-call and PRIME roles on weekends on a roster with the GP, so they differed from the majority of the nurses in this study who worked predominantly alone:

*Nurse one: One thing that's bothered me about doing this all the way along is that if something does happen and somebody happens to die and we live in this wee little town ... and they're saying somebody died and it was one of those nurses on-call you know. We're just not sure how the town actually feels about us.*

*Nurse two: They are very happy at the moment because everything's gone on very sweetly and it's cheaper to come and see us and you know we are very obliging and everything works out. But on the law of averages, something's going to happen whether it be an MVA [motor vehicle accident] or a cardiac arrest [heart attack] or something minor that blows up but just how the repercussions from that will go, I don't feel very confident about ... We all know how they react with the GP when things go wrong and there's no way we are going to be any different because he's the whipping boy ...*

*Nurse three: It will be worse, because at least he's respected.*

*Nurse four: They'll say, those nurses should never have been doing on-call.*

The above nurses had previously done solely traditional nursing roles in their community and the transition period for them to taking on-call work highlights the

uncomfortable positioning of nurses in relation to the responsibilities of emergency work. Further, nurse three suggests that the nurses would be treated more harshly by the community if something did 'go wrong' because they are not respected in the same way as the doctor is. This perceived lack of respect appears to be tied to the traditionally mandated position that the doctor holds as an attender at emergencies (within expected role boundaries), whereas nurse four seems to be saying that the nurses carrying out this emergency role have a borrowed status that at least potentially leaves them open to the damning criticism that they should never have been doing the role in the first place. Living and working in the community in which they provide this emergency service thus places these nurses in a difficult, if not uncomfortable position.

Aside from the emergency role, the provision of regular health care includes types of surveillance that challenge boundaries between nurses and patients. In a sense, neither the nurse nor the patients can escape from each other. The nurse is never not the nurse and patients are never not patients. While this enmeshing of public and private identities can be constraining for the nurse, it may equally constrain patients' behaviour:

Nurse: *They think I am always the nurse. I don't go out much now in the community, I mean I go to select places but I don't go to the pub or anything like that now I really just can't be bothered in a lot of ways and it's really interesting if I am there...[a local person might say]. oh I shouldn't be drinking, I should .....I think I don't give a damn what you do, that's your problem, that's not mine. I'm out, I'm not on duty, I'm out.*

LT: So they see you socially as sort of like the health police?

Nurse: *Yes. Well I suppose you could say that and I just roar laughing and say well don't look what I am up to.*

Laughter.

*But it's just that, it's just them. They don't realise that you are not actually thinking, oh there's old Joe Bloggs drinking or whatever, I know what they do, I don't need to think about it, you only need to look at their test results, you know what they are doing, don't have to think about it, but it's just people, and it's just humans, and humans in small community. It's just a rural, cultural thing. (Rural registered nurse. 2002)*

The nurse already has health/illness knowledge of the patient since nurses order tests and pay attention to the results that the tests show. For patients, though, a face-to-face encounter with the nurse reminds them that they may not be supposed to be doing what they are doing, their lifestyle comes into question even if fleetingly (see Petersen and Lupton 1996 for an extensive critique of this lifestyle governance). The very presence of the nurse serves as a reminder of 'health messages' that the patient has been supposed to absorb and act on. The nurse, in this sense, embodies neo-liberal governmental imperatives that encourage individuals to take responsibility for their own health; to moderate drinking, or stop smoking or get more exercise, in short to modify their embodied selves.

Health education tends to be seen as something which is in the public good, and quite literally 'good for you'. But Foucault (1990) has argued, using the concept of bio-power, for a more critical stance in relation to the seemingly willing behaviour modification in which we all participate to a greater or lesser degree. Foucault documented a shift in the management of populations, beginning in about the seventeenth century. This shift entailed a move from sovereign power which was essentially power over life and death, to a much more subtle power over life. "Bio-power, or power over life, constitutes power employed to control individual bodies and populations" (Gastaldo 1996: 114). Bio-power in the form of health education is very mixed, ranging from empowerment to subjugation, and from liberation to docilisation and so cannot be assumed to be an automatic good (Gastaldo 1996), but neither is it automatically and simply 'bad'. Thus, surveillance is not a simple negative concept, but rather, it is far more complex than that. Pecora (2002) interestingly argues that while Foucault's notion of surveillance was one acknowledging the coercion and production of social relations, the focus for those

using Foucault's work has often on surveillance as morally regulative activity. Pecora's argument is that the "desire to watch and be watched is a more deeply rooted element of the liberal democratic impulse than we normally care to admit" (2002: 345). But, the deployment of power must always be attended to in such understandings as Pecora's, as some critical writers on surveillance are all too aware (Koskela 2000). The ambiguity of surveillance remains as is illustrated in the following example.

Nurses from one of the geographical areas represented in this research indicated that because they know their community so well, they are able to practice interventions that, for instance, have significantly reduced the hospitalisation rates for people with diabetic complications. Since many of the patients in their area do not relish the idea of hospitalisation with all its attendant problems of visiting access and so on, that are part of having to leave the rural area to go to hospital, then in this case, and on balance, surveillance is probably a 'good'.

The philosophical adherence to the idea of holistic care provides a platform for sense-making for rural primary care nurses. But, it may also serve to set them up as 'health police' due to their highly visible roles, intentionally or unintentionally and also subject community members to levels of surveillance that they may not desire. Levels of surveillance are mutually constructed however, with nurses being subject to surveillance at the same time as they exercise surveillance. While claiming not to give a damn about what patients do, the above nurse's behaviour is nevertheless altered in that the nurse's social activities have been modified. But when out, the nurse simultaneously constructs a boundary about *where* (not at the pub) s/he will *care*, by saying *I'm out, I'm not on duty, I'm out*, but at the same time is unable to escape the knowledge that the nurse already possesses about the patient, gleaned from test

results. The nurse is also aware of the potential interest in what s/he is doing by saying *well don't look what I am up to*.

Incomers of any sort are highly visible in a rural community, but more so if they are to provide a service such as health care. One nurse was amazed at how much knowledge the community had of both the nurse and the nurse's family prior to their arrival in the area. This particular nurse lived in the accommodation attached to the local hotel for some weeks before an appropriate alternative could be found. This experience left the nurse feeling very much observed, since all the nurse's meals were eaten at the hotel where local hotel patrons would comment on what s/he was drinking.

The continued use of holism as a more complete model of care as a way to make sense of their work by rural nurses depends on a particular understanding of community. The ability of nurses to sustain these, flexible, generalised, demanding roles, at least in part, depends upon a certain expectation of 'locals' as self-reliant and so does not mean doing everything for everybody all the time:

*I find the community very self-reliant and it's really good to foster that...Once you know your population, you know the people that you can give advice to over the phone and catch up with in the morning, if this is at night. Or, you know those who have only rung you in desperation that you know if they have rung you they need to see you now. That makes your job a little easier (Rural registered nurse. 2002).*

There is a delicate balance involved in attempting to have a community 'self-sufficient' in terms of their health care. Traditionally, rural people have been very aware of the need to protect what health services they do have and so may have been reluctant to 'bother' health practitioners. This reluctance may not have served their health needs as well as it might. Yet the need to have the local community able to self-care to at least some degree is crucial to the continuance of these nursing roles. In some cases nurses are on-call for eleven days at a stretch and the amount of call-outs,

particularly at night, obviously needs to be minimised in order that the practitioner can cope. Holism as a philosophical basis for nursing care can only, realistically, be applied to the local community while non-locals are subject to a less 'rounded' model of care.

### 'Others'

Both locals and nurses, as locals, can 'other' (see Cloke and Little 1997) those who enter their space even if these visitors are essential to the local economy. 'Others' may take the form of tourists, seasonal workers or sportspeople. This othering necessarily reproduces stereotypical understandings of rural communities and people as exclusive and perhaps also drawing on deeply held understandings of rural people as resourceful and self sufficient due to their remoteness from major urban centres. This self-sufficiency and resourcefulness, where locals know, for the most part, how to manage their, sometimes challenging, environment is set against the potentially dependent relationship that visitors are in when they visit rural spaces, sometimes needing to be towed out of ditches by farmers and so on. Locals live the rural while visitors sample the rural. The large numbers of seasonal workers in the tourist and agricultural industries belong neither to one group or the other. They are neither local nor purely visitors but inhabit an in-between positioning. I would not go so far as Sibley (1997) does when he discusses "nomads and youth cultures" as somehow abject in rural spaces in the English countryside, but the needs and demands of New Zealand tourists and visitors to rural spaces are contained in similar ways to that required of the abject.

In terms of health care, different sets of expectations apply to non-locals. If the nurse is called by a non-local person, they do not have the benefit of prior knowledge,

on which to base a clinical judgement. The high flows of overseas tourists present additional challenges in that a number of them speak very limited English and the provision of adequate health care depends on the assessment made by a practitioner after a history is taken. Adequate communication is vital to understanding the nature of the problem, but is not always achieved. Tourists, from overseas and locally, and also seasonal workers present challenges, both in terms of sheer increase in numbers, and in terms of expectations:

*They are a lot more demanding, have much higher expectations of the service. I mean, if I get called by a local, I know they need to see me. If I am called out by an out-of-towner, chances are it is something petty. Not always, but quite often it is, and they tend to dramatise a lot more. I'll get there and find it's actually something quite minor that could have waited 'till the next day. But that becomes a little bit more difficult....because with people who are just transitory, you don't know, and the stories that they are giving you are all you've got to go on. So, sometimes you do need to see them face-to-face. It is a bit of a hack-off when you find they definitely could have waited until the next day and you have dragged yourself out at ten o'clock at night or something (Rural registered nurse. 2002).*

This nurse also says that there is certain amount of satisfaction in that these so-called, out-of-towners, pay. For the people 'local' to all but two of these areas the health services provided by nurses are either very inexpensive (up to \$5) or free since the service is predominantly funded by the local area health board. This free service is not extended to non-locals. The autonomy assumed by the nurse to alter the fee after making some kind of judgement on the need for the call out would be less likely to be drawn upon if the nurse was self-employed. The employer, be it a district health board or community trust hence provides a buffer zone in which this flexibility can be exercised.

*... it was always a free service, and because anybody who is a non resident is charged, I charge as a nurse. They think, you know, because the locals send them in because it's a free service and they come here and I have to say, well it's not free, do you want to continue? I am most probably not as good at charging as I should be but basically to keep roles going and to keep these*

*roles alive, you just have to do these things. It's just a sign of the times. ....I mean they can be charged a nominal charge or they can be charged an astronomical charge and sometimes it is actually done on nuisance value. (laughter). To be perfectly honest, if they have been an absolute pain in the butt and just expecting major city hospital treatment in the middle of the night for an ingrown toenail or something, I'm quite happy to charge them \$75. Quite happy to charge them that. If they are desperately sick and going in the ambulance, they often don't get charged at all. I maintain they have got enough problems without me sticking something under their nose (Rural registered nurse. 2002)*

This final nurse draws on self-defined boundaries between nuisance and legitimate patient identities in much the same way that doctors construct nuisance and legitimate identities when nurses request to admit patients to hospital in some cases. Both nurses and doctors are gatekeepers in these examples, the doctor as the gatekeeper of the hospital admission (although it may be possible for a nurse having trouble getting support from a doctor to simply try to call another doctor), and nurses as gatekeepers of any health care whatsoever. The nurses in the most remote places (those places located a long distance from any other service) are thus positioned as powerful players in the health care setting.

### **Concluding comments**

The relations between medicine and nursing have traditionally been characterised by the simultaneous construction of boundaries around medical and nursing knowledges. In rural and remote areas, nurses have exceeded these boundaries for about a hundred years, but as their roles become more visible and nurses working in other environments seek to extend and expand their practice, particularly with the nurse practitioner credential, anxieties surface, both from nurses and doctors. In some ways rural nurses have been located below the radar screen and have just got on with the job, but in an age of increasing credentialism, and particularly increasing

accountability, there are few, if any sites of practice that escape some type of surveillance.

As well as being located in a discursive field of ‘anxiety’ regarding their positioning in health care delivery, rural nurses also examine their professional identities for a fit between their perceptions of what they perceive nursing is and what they are actually doing. Nurses need to construct a notion of ‘appropriateness’ about their practice if they are to maintain coherent professional identities the conduct of which they can govern. In order to attempt to make sense of the ways that their type of nursing escapes the boundaries expected of nursing, or what is appropriate to nursing, rural nurses draw on discourses of holism to attempt to span the breadth of the roles they do and to position themselves firmly as rural health care practitioners, rather than mini doctors.

Holism appears to be a tactic utilised by nurses in general to assert their difference from medicine, but its particular deployment in rural primary care practice is also as a response to the exigencies that are faced in practice. But providing holistic care in a rural environment places heavy demands on the nurse in social, professional and spatio-temporal ways, the outcome of which is an intense relationship of mutual surveillance between nurses and patients. Thus the very practice of holistic care co-constructs the rural as a particular type of surveillance space where nurses are both the watchers and the watched. This mutual surveillance space and the type of health care it facilitates should be of significant interest to health policy makers interested in providing targeted and effective health promotion.

Where I began by talking about the fluidity of role boundaries, it is perhaps more accurate to say that nursing ebbs and flows across these boundaries, but medicine does not. It seems that medicine relinquishes control over certain parts of

work traditionally deemed to belong to it in certain places and in certain circumstances. It would seem to be the case that nurses and doctors are not interchangeable, but that at the edges of the practice of each there are parts of roles that either can do. Over time, however, it is more likely that nurses will move more onto medical terrain than doctors will move onto nursing terrain, if what has happened historically is anything to go by. I am not interested here in advancing the argument that rural primary care nurses should or ought to be aiming to take over the roles of doctors, but merely the ways that nurses in rural places currently provide primary health care gives a glimpse of a shift in focus.

I see no reason to suppose that there will be major change in the role expectations of rural and remote nurses in the near future. In some sense these practitioners can be argued to be leaders in boundary work negotiations between medicine and nursing and perhaps can offer a model of care that could be extended to other areas of primary health care. Although I have no wish to fuel antagonisms between nurses and doctors who are engaged in boundary work, it seems absurd to continue to not acknowledge that there are practitioners in rural places, whose models of health care encompass far more than current urban models of primary care do. It can either be argued that these are stopgap models that are just waiting for the ‘solution’ in the form of more rural doctors, or I can take seriously the argument advanced by Pringle (1998), Davies (1995a, 1996) and Lerner (2000), that bureaucratic organisations and neoliberalising processes rely on the work of women even as they deny it, inciting women to do for free, what was previously the preserve of the state. So long as autonomous rural/remote nursing work is constructed as a stopgap, then the implications of the fact that nurses are currently doing these

comprehensive roles, do not have to be unpacked, and nurses continue to construct governable professional selves, so mitigating risk as far as is possible.

The following chapter explores the governance of these border-negotiating professional identities at an even finer spatial scale. This chapter has been concerned with the ways that nurses negotiate ‘mobilities’ across role boundaries. Using the example of physical mobility, the following chapter investigates the ways that nurses’ practice is governed by technologies of the self. While initially suggesting that the practice of rural primary care nursing work is a highly gendered (feminised) work practice, the chapter suggests that these feminised professional identities are overdetermined by their professional identities. The performance of this professional role is discussed within the understanding of the state and the profession as interdependent rather than separate so allowing for a more comprehensive idea of how rural professional identities are self-governing.

## 6

### **Mobile Professional Subjects: Governing (im)mobility**

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#### **Introduction**

The previous chapter investigated the ways that rural primary care nurses negotiate interprofessional boundaries and use a discourse of holism to construct a broad notion of appropriate and coherent professional conduct. The practice of holism serves to co-construct the rural as a particular type of health care surveillance space where ‘everybody watches everybody’. While nurses’ practice may be governed to some extent by this ‘watching’, as we saw in chapter four, their practice is also governed by the ‘shadow of the law’ and, as chapter three indicated, nurses are governed to some degree by historical notions of professional ideology. Nurses also govern their own practice utilising techniques of self-surveillance. What may be seen at first glance to be a highly gendered performance of rural professional work, is rather more complexly configured as the construction of an emplaced, self-regulated, professional identity. Much of the content in this chapter has been previously published (Thompson 2004).

This chapter explores a finer spatial scale than the previous chapters, and examines the ways that nurses govern their own everyday practices using ‘technologies of the self’ (Foucault 1988). Drawing on the ways that rural primary care nurses are simultaneously mobile, in terms of moving to rural work, and confined within the practice of their work, this chapter deals specifically with the ways that nurses utilise techniques of self-surveillance to construct ‘appropriate’ professional

conduct that simultaneously constrains their own behaviours. This appropriate professional conduct positions nurses as 'reliable' performers of primary health care work. Investigating the way that nurses re-work notions of spatial constraint goes some way to aid in understanding the investments that nurses have in relocating to this type of nursing work.

In the light of the relative lack of attention to spatial constraint within workplaces/spaces, and also focusing on the ways that this small group of rural nurses seem to contest expected stereotypes of gendered immobility, Foucauldian understandings of 'governmentality' are useful in order to explore the ways that nurses are located as simultaneously mobile and confined. As already noted in the introduction, I understand governmentality to be the conceptual point of intersection between technologies of power (rule by force), and technologies of the self (which induce consent). In many ways the interaction between technologies of power and technologies of the self have been easier to identify in previous chapters. In chapter five for instance, the law can be seen to be a technology of power, while defensive practice, where nurses engage in self-monitoring techniques to manage risk, can be seen as a technology of the self. The convergence of technologies of power and the self, taking form as governmentality, take a much more subtle and conceptual form in this chapter, which focuses most on technologies of the self. In order to begin to understand the complexity of the spatial relations within which nurses are located, theories of governmentality allow for the exploration of the positioning of professional work within relations of ruling and to explore how 'autonomous' professional subjects are governed at a distance by stimulating them to govern themselves. Utilising the framework of governmentality allows for an understanding

of how, in the absence of structural constraints on mobility, nurses appear to confine themselves.

The chapter is organised into three parts. The first looks at mobility and constraint in general terms and examines the flexibility of rural primary care nurses and deconstructs the notion that there is a clear mapping of gendered rural identities which explains nurses (im)mobility. The second section looks at the ways nurses draw on discourses of ‘autonomy’ to explain their positioning in rural/remote places, and how they construct themselves as both resistant and mobile subjects. The analysis of this simultaneously resistant, mobile, but also constrained professional identity, is facilitated by examining the relationship between professionalism and expertise in the contemporary state, introducing the ways that health professionals govern their own conduct by using technologies of the self. The third section looks at the ways nurses use technologies of the self in their everyday practices, including the ways that nurses negotiate the duty of care and ethics of care, and splitting identities. These technologies of the self are means by which professionals govern their own conduct with little need for direct intervention by the state. ‘Appropriate professional conduct’ can thus be assumed of rural/remote nurses. As such, nurses confine themselves by recourse to understandings of appropriate professionalism which serves to subtly govern their conduct. Nurses deploy the notion of autonomy and practise self-surveillance. Autonomy and constraint in this sense are not in conflict with each other, but rather rely upon each other for the ‘appropriate’ performance of professional work.

## **Mobility and constraint**

I began my research assuming that the majority of the nurses in the most remote places would have come from the areas in which they now worked; that is that they would be rural women reliant on rural labour markets (see Hughes 1997). But, I was interested to discover that thirteen of the participants had moved to the areas that they were working in for the nursing jobs, including three of the four men in the study. Many studies (Laws 1997; Hanson and Pratt 1995; Bruegel 1996 among others) have shown that mobility, both in terms of travelling, and moving for work is highly gendered and there are a number of ways in which women's work is spatially constrained; the so-called spatial entrapment thesis. Hanson and Pratt (1995), for example, in their study of Worcester, note that women tend to work closer to home than men, and are, thus, more dependent upon local labour markets. Authors such as Gilbert (1998) however, argue that there are limitations in equating mobility with power and immobility with powerlessness. Thus the spatial entrapment thesis is essentially flawed in so far as it undertheorises social relations other than gender, such as race for example. Examining the crosscutting differences between women highlights some of the limitations of the spatial entrapment thesis.

Locally, the situation would appear to bear out the spatial entrapment thesis. A study carried out on several hundred nurses by the New Zealand Nurses Association found that "nurses mobility is severely limited by family commitments – 71% state their freedom to move to another job outside their present location is 'entirely dependent' on other people" (*Kai Tiaki* Sept 1992: 15). Bielby and Bielby (1992), Hendershott (1995) and Bruegel (1996) have considered the issue of women moving for a male partner's work. To some extent the nurses in this study have reversed the expected and have moved against the grain, in the sense that the city is the magnet for

employment. In two cases there are actually male partners who have relocated for the female nurse's work. Perhaps I need to pay close attention to the remote nurse who said "we're just not regular folk". Although there are certainly some nurses who have 'grown into' their jobs in the rural area, the presence of those nurses who have actively chosen the work deserves attention in order to explore the potential for the rural/remote nursing role to contribute in other sites.

As already indicated, the rural nurses in question here provide the widest definition of health care to their communities. Their work encompasses everything from the mundane sore toe, to the highly acute car accident. The practice of this clinically flexible professional work disturbs notions of discrete and confined boundaries between medicine and nursing. Even as rural nurses escape confinement within traditional understandings of nursing roles, and 'confinement' within hospital work, they are constrained in other ways in the context of their work. As is indicated in the following quotation:

*I'd love to do some night classes; I can't because I'm on-call in this district ... things like that. You sort of sometimes think, oh it would be nice not to have that. It feels like a bit of a leash at times, you sort of get to the edge and you are not allowed any further. So that can hack you off ... (Rural registered nurse. 2002)*

Rural primary care nurses are highly spatially constrained in the practice of their work, but in less immediate and tangible ways than they are in the hospital setting.

Hospital nurses work in materially constrained environments (Halford and Leonard 2003). Nurses' places of work are confined to, at least, a particular building, and often a particular ward in that building. In contrast to nurses who work in hospitals, nurses who work in the community already work at the borders of direct surveillance of their work by others, be they colleagues, subordinates or superordinates. Nurses who work outside of hospitals in the community also push the

boundaries of what the workplace is and this counters the positioning of the hospital as the dominant site for the delivery of health care. When the community becomes the workplace as it does for rural primary care nurses, it does so in a much more encompassing way than is the case for a nurse working in the community in the city, since city nursing allows for some degree of anonymity in off-duty time.

Many people living in cities working in professional roles can, more or less, step outside their professional identities when they are not in the workplace<sup>29</sup>. It is extremely difficult for rural professionals of any sort to leave their professional identities behind unless they leave the rural area (see also Mellow 2005). As McDowell and Court (1994) indicate professional identities are constructed in and through the workplace. For rural/remote nurses (and many other rural professionals), the borders of the workplace are fluid; so fluid in fact that the whole geographic area in which they live becomes the “workplace”. The on-call component of the most remote work exacerbates spatial confinement. The microspaces in which nurses are embedded by virtue of their work serve to confine nurses in very concrete ways.

Having exercised agency in moving to rural nursing work, in the most remote areas nurses find that they are very physically spatially constrained due to their on-call commitments. Although within this constraint nurses decide when they will have clinic hours and school visits for example. So within the extreme constraint, paradoxically there is also a high degree of control over the day-to-day work space, barring unexpected things such as car accidents or acute illnesses. The above literatures concentrate on mobility between workplaces but literature examining spatial constraint/negotiations within the workplace, when the workplace is a bounded rural area is lacking. A striking exception to this lack (although dealing with the

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<sup>29</sup> There are, of course, exceptions to this ability to pack a part of one’s identity away should one so desire. People who have a high profile in local or national terms are less likely to be able to exercise this option.

hospitals environment) is the work of Halford and Leonard (2003). They investigated nurse's access to space, movement through space, and the different meanings of spaces within two hospitals, as well as the implications of this spatialisation for nursing identities. Halford and Leonard's (2003) work strengthens both the argument that spaces and identities are mutually constitutive, but also more simply, that hospital work is spatially constraining for nurses. But this spatial constraint is reengineered by nurses in ways that highlight the complexity of the workings of power. For example, nurses' familiarity with ward spaces is used as a source of power in their interactions with doctors and managers (Halford and Leonard 2003: 208).

Also of relevance to issues of constrained mobility is the research that has considered the problematic nature of on-call work. While a number of studies have indicated the onerous nature of on-call work, they have not explored the issue in-depth but merely indicated its presence, (in relation to doctors see Dowell et al. (2000) and Janes et al. (2001), and in nursing see Smithers (1995)). Both rural clergy and particularly rural police must experience similar types of spatial constraint, but I have so far only been able to locate one article relating to clergy (Mellow 2002) in which the researcher found that the families of rural clergy become 'buffers' against the demands of rural work. The encompassing nature of rural policing is indicated in Weisheit et al. (1994). While rural teachers may experience some of the same constraints as nurses, there is no legal or moral (as there may be for clergy) requirement for them to be available out of normal work hours. The lack of attention to the high demands that are placed on rural professional workers raises questions about rural identities in general and rural gendered identities in particular.

## Gender, identity and mobility

The characteristics of the nurses who have relocated to rural and remote nursing are many and varied and there are as many reasons for relocating as there are nurses but there were some common features and themes. Only two female nurses, and none of the male nurses, had children at home consistently. Of the two female nurses with children at home, one had a partner who was the children's day-to-day caregiver. The extensive on-call commitments that this nurse was required to do did present some problems in the family. The second nurse struggled to accommodate on-call work around a partner who worked away from home on an irregular and unpredictable basis. This second nurse indicated that negotiating childcare needs and on-call work was a source of significant tension in the household. While I indicated in chapter two that I may have unwittingly caused nurses to focus less on the family/work nexus as a result of the interview locations, the overwhelming majority of the nurses had no day-to-day childcare responsibilities. Of the female nurses who had relocated for this work, seven were single. Of the four male nurses three, as far as I am aware, did not have children and the remaining male nurse had one child at boarding school. Three of the male nurses had very actively chosen remote nursing work and the other had moved to the rural area for a lifestyle change and had fallen back into nursing as the other nurses in the area became aware of his training.

Whatever the reasons for locating to rural primary care nursing work, the ways in which nurses are located in terms of their professional work performance can be analysed on one level as a highly gendered (feminine) work practice in the willingness to accommodate high levels of spatial, temporal mobility and immobility and clinical flexibility. As was indicated in chapter three, the feminised nature of nursing work has strong historical foundations and in the contemporary context the

low numbers of men entering nursing has not served to disturb this feminisation.

Nursing is not alone in being gender specific, as McDowell (1997: 25) states:

Jobs are not gender neutral – rather they are created as appropriate for either men or women, and the set of practices that constitute and maintain them is constructed so as to embody socially sanctioned but variable characteristics of masculinity and femininity.

When men are present in rural nursing their masculinity contests conventional understandings of rural masculinity and who a nurse ‘should’ be:

*Some of them have difficulty coping with me as a male nurse because I’m gay, and there’s a lot of homophobia around. And those who are lucky enough to have necks, their necks would be red. Some of them don’t even have necks. The majority of people just think; fine. They really don’t care and they know I do a good job (Male rural nurse. 2002).*

While this nurse constructs himself as ‘out of place’ (Cresswell 1996) for some people, those he describes as “red necks”, because he is gay, his professional identity gives him currency in that the “majority know I do a good job”. McDowell and Court (1994), following Butler, suggest that:

the construction of an individual’s gendered identity is a performance or a fabrication, the aim of which is the production of a coherent identity. This identity, for the majority of the population, is based on what Butler terms “the regulatory fiction of heterosexual coherence” (1994: 731).

His professional identity passes as coherent, while his sexual identity may remain incoherent to some local people. Another male nurse makes claims to the performance of some stereotypical masculine activities, yet he notes he was still anomalous, at least for a time, because he was a male and a nurse:

*they didn’t talk to me for 6 months when I came here, being a man as well, they thought that was a bit weird, but they got over that pretty quickly. I’ve always been a keen hunting, shooting, fishing, love photographing bird life, so you know from that point of view it’s ideal for me (Rural male nurse. 2002).*

This nurse positions himself in a very complex way and in a sense uses the intersection of his masculine identity, professional identity and place to make sense of his discursive positioning.

If the performance of masculinity in rural primary care nursing is anomalous, at least for a time, then what of femininity? Although not mentioning gendered behaviour specifically, the reference to a 'guilt quotient', made by the following nurse, indicates that a sense of 'guilt' governs to some extent what the nurse is willing to do and conjures traditional gendered notions of vocation. In the following example the nurse indicates that the job description has changed so that the nurse should only be working a forty hour week and if on-call work is done, the time that is dedicated to that can be 'taken back' as time in lieu. But, as the nurse indicates, there is no time available to take as time in lieu:

*I'm sure when they pick people for this job they check out your guilt quotient, you know, how many guilt things they can lay on you. Giving more and over and above....Our contract has just changed, but it was that we worked a forty hour week, and any over and above that, on-call or whatever, you could take back at some stage which was ludicrous because your general run of the mill work just totally nullifies that (Rural registered nurse. 2002).*

The idea of working for nothing (payment or time in lieu) present in the above transcript when the nurse says 'giving more and over and above' is much harder to limit in a rural community with the demands being very proximate. It is probably fair to argue that most peoples' work in rural places spills over the boundaries of time and role boundary type, especially in very remote areas where resourcefulness and adaptability are necessary for the community to function. If farmers, for instance, were not able to mend some of their own equipment then it is conceivable that it would become impossible for them to farm in outlying areas. This resourcefulness and adaptability has been immortalised, somewhat tongue in cheek, in the idea that rural people (usually men) can fix anything with a piece of number eight fencing wire.

The notion of the ‘rural idyll’ (Mingay 1989), with its image of the rural as a haven from the “brutalities of urban living” (Campbell 2000), may be re-worked to some extent in the New Zealand context with the persistence of a type of frontier mentality. But, be that as it may, images of the rural conjure imagined social spaces in which “people live closer to nature and simpler and (by implication) happier lives” (Campbell 2000: 562). Part of this ‘living closer to nature’ has included the adherence to traditional gender roles (Watkins 1993; Little 2002). Rural identity literatures have made claims about the ways that rural femininity is constructed. Little, for example, indicates:

that while gender identities in rural areas are multiple and fluid, there is a set of characteristics associated with the rural woman and (arguably less so) the rural man through which their gender identities are defined. These characteristics place emphasis on the conventional family roles of women and men and on the economic and social relations which support them (2002: 41).

These characteristics that Little talks about have been noted repeatedly by researchers studying rurality and gender and are generally more marked than is the case in urban areas (see for instance Stebbing 1984; Hughes 1997; Little 1997). The conjunction of femininity, rurality and profession creates a particular set of tensions. It would be very easy to argue that the above transcript about a ‘guilt quotient’ indicates the gendered passivity of rural nurses in the face of a very constrained local market for professional work. But, given the agency exhibited by the nurses who have relocated to this work clearly there is a greater level of complexity involved in the investments that nurses have in the decisions they make.

It seems that nursing has the potential to de-stabilise conventional understandings of rural gender identity, even while it supports some of them. The very demanding practice of this flexible professional work both reinforces and contests conventional rural women’s roles in that the very availability required from

the nurse precludes the commitment to conventional gendered roles that are based around family needs. Both Hughes (1997), and Watkins (1993) indicated the ambiguous status of single women in rural places and their lack of 'fit' with rural life more generally, but did not push this analysis very far. Further research into being single in a rural place has the potential to clarify this analysis. It could be that gender identities come to be eclipsed by professional identities. Indeed Moore indicates that:

The co-existence of multiple discourses, however, produces a situation in which the different discourses on gender are hierarchically ordered. This ordering may be both contextually and biographically variable, as well as being subject to historical change. The result is that some discourses overdetermine others... (1994: 59).

The important point to be made is that there are competing claims on nurses' identities, and that discourses of rural femininity may not therefore be dominant. Thus in terms of professional nursing work, the rural location presents a space that is simultaneously an opportunity (in terms of moving to more autonomous work), and a constraint (in that the nursing work physically constrains the nurses who are on-call). Within this ambiguous space that is rural professional nursing work, nurses make sense of their positioning by drawing on discourses of autonomy and independence.

### **Autonomy and independence: resistant professional subjects?**

Those nurses who have moved to the rural area for nursing work draw on concepts of autonomy and independence in order to explain their 'choice' to work in rural places. Rural/remote nurses construct themselves, in some sense, as resistant professional subjects, who are able to be autonomous in ways that they may not be able to in the hospital setting. In this sense they can be argued to have resisted 'confinement' in

hospitals. The following two quotations draw on similar notions to explain the desire to get out of the institutional hospital setting:

*When I returned I recognised that having basically had four years away from a fairly structured workplace I should do a bit more nursing. So I went back and that's when I did my second stint at the hospital. But within about nine months I really recognised it was not for me. The whole idea of being just a lone voice, or that's how it felt, amongst the big workplace where your opinion or your value was hard to get recognised. I just felt I couldn't really make a difference. I think probably, partly, that was because I had worked in private workplaces too, not the structure of a tertiary government funded setting (Rural registered nurse. 2002).*

The following nurse also draws attention to the focus on budgets, perhaps at the expense of what is perceived to be 'good nursing care' as the motivating force towards taking a job in which there was more direct control over the nurse/client interaction:

*The big hospital's very impersonal. It's all numbers and money and budget. The thing that really frustrated me was that I knew that we weren't delivering good nursing care and we had the capability of doing it. That's what really used to annoy me. Down here, I'm pretty much my own boss and I can make a direct input to my client, to my patient (Rural registered nurse. 2002)*

One nurse, when asked what was good about working rurally concurred with the above nurses, and said: "I didn't want to be stuck in an institution" and went on to say:

*Look out the window, snow on the mountains, fresh air, rivers down the road to go fishing after work, beach out the back 100 yards away. The autonomy, the independence and the way to be a nurse in the way I want to be a nurse within the confines of the boundaries of what the establishment says how to be a nurse, if you know what I mean. The independent practice, and I can just do it how I want to. Nurse how I think nursing is, which is holistic, inclusive, caring about everybody and trying not to be rude and being a bit of a role model in the community etc, etc (Rural registered nurse. 2002).*

While identifying and valuing autonomy and independence as allowing more control over how nursing is performed, this nurse also draws attention to the bounded nature of that autonomy. The 'establishment' is identified as the holder of the definition of what it is to 'be a nurse', yet this is not perceived as so confining as it might be in an

institutional setting. The way that this nurse has identified the complexity of bounded autonomy highlights questions about power and resistance; the duo that Foucault (1990: 95) perceived always operated together, explaining that power can only exist alongside resistance; power is not power without resistance.

Having moved away from the hegemonic hospital or institutional nursing utilising mobility nurses have resisted the powerful centre for the margins. They have moved out to work in the community and have moved even further out where they can utilise concepts of autonomy and independence in order to be able to practise in the way they want to practise. Resistance has been perceived as a response that those on the margins, or in less powerful positions, may make to challenge their positioning. However, concern has been expressed in regard to a dichotomised understanding of power and resistance.

Power and resistance have often, if not usually, been thought of in oppositional terms, even if this was not Foucault's intention. But, as these concepts have been examined more carefully it has become important to move beyond a dualistic formulation (Cresswell 2000). Cooper has usefully pointed out that rather than seeing resistance as the antithesis of power it is more productive to see it as a "motivation for power's deployment" Therefore, "those who resist are exercising power as much as their oppressors"(1994: 441). In Cresswell's words then, resistance, such as that exhibited by the nurse above, "becomes the deployment of power with the motivation of alleviating or transforming the conditions under which one lives" (2000: 264), or in this case, works. In resisting, nurses exercise the power of autonomy and independence, but that autonomy is simultaneously undermined as the nurse's role performance is constantly under surveillance, but this surveillance does

not operate in clear cut ways. The ambivalent nature of autonomy and surveillance is evident in the following quotation:

*I can go six weeks to two months without hearing from my manager. I've been known to comment once that I could be running a brothel up here and she wouldn't know. She said, yes I would because the linen use would go up. I said, well actually no it wouldn't because that shows you how much you do know about the area because linen is laundered locally, so you actually wouldn't know. I don't know whether to feel neglected or whether to pat myself on the back because I'm doing a good job so I don't need to be pursued (Rural registered nurse. 2002).*

One of the nurses above indicated that “being a bit of a role model” is perceived to be part of nursing. Acting as a role model implies that ‘others’ are watching one’s behaviour for cues as to what is appropriate. What at first may appear to be a panoptic gaze (Foucault 1977) on the part of the nurse, as authorised keeper of the public’s health, is thus rather more complexly understood as mutual surveillance. Indeed this complex game of ‘mutual surveillance’, which has already been addressed in chapter five, has many players, not the least of which are the communities in which the nurses work, doctors with whom nurses liaise (however indirectly), managers (however remotely), and of course the state. In these terms then, rather than attempting to highlight the ways that rural nurses resist power by moving out to rural work it is more important to recognise the complex, messy, nature of these constructions of autonomy and independence, and what the bounded nature of rural professional practice might be.

Part of the complexity that nurses negotiate stems from the particular positioning of the health care professions within the contemporary state. While in common-sense terms health professionals may wish to construct themselves as patient advocates and distance themselves from the workings of the state apparatus and political investment, there is a much more finely nuanced relationship between health professionals and the contemporary state.

## Professionalism and expertise in the contemporary state

While the professions set up the notion of autonomy as something that “belongs” to them and which is in opposition to state control, the concept is located in a more complex relationship to the state. Thus, the concept of autonomy requires more analysis. Johnson (1995), reviewing the sociological literature on the relationship between professions and the state, identifies a dichotomous understanding of this relationship. The problem, he suggests, is the way in which the debates have conceived of:

state/profession as a relationship between preconstituted, coherent, calculating political subjects; one intervening, the other seeking autonomy. While the professions are seen as acting to maximize autonomy, the state is presented as continuously extending its apparatuses of control throughout society, including over the professions (Johnson 1995: 9).

This formulation limits investigations of the positioning of professionals within the state, since following Foucault, it is argued that “the modern professions emerged as part of that apparatus that constitutes the state” (Johnson 1995: 12). Johnson goes on to argue that this autonomy is “an outcome of political processes, far from being reduced by ‘state intervention’, is a product of governmentality that brings the state into being” (Johnson 1995: 22). If we can see governmentality as the conceptual point of intersection between technologies of power (rule by force) and technologies of the self (which induce consent), then the concept of professional autonomy provides an excellent example of this point of intersection (see also Bondi 2004). Neither the state by exerting force, nor the professional by exercising autonomy predominate, but rather a conceptual space is created in which professional autonomy and state control are held in tension. Professional autonomy is part of the process that brings the state

into being and neither can function without the other. As Perron et al. (2005: 536) argue:

Nurses are at the flexing point of the state's requirements and of individual and collective aspirations. They occupy a strategic position that allows them to act as instruments of governmentality. Consequently, nurses constitute a fully-fledged political entity making use of disciplinary technologies and responding to state ideologies.

Professionals, including nurses, are thus implicated in the apparatus of the state (Holmes and Gastaldo 2001) and as such cannot be seen to really practise beyond surveillance completely, although they can see themselves as practising at the boundary of *direct* surveillance. In this way professional 'autonomy' is that which the state relies on to carry out its work of governing the public. That is not to say that discourses of autonomy may not be utilised by rural nurses as a sense-making tool, but that there are wider arguments to be examined in the context of professional autonomy and the state.

Gordon (1991: 2) indicates that Foucault "proposed a definition of the term 'government' in general as meaning 'the conduct of conduct': that is to say, a form of activity aiming to shape, guide or affect the conduct of some person or persons". For Foucault this conduct is not usually shaped by coercion or force but rather by much more subtle means. For instance, one of the key ways that the conduct of conduct is operationalised is by the use of professional 'expertise'. Professional expertise is a tool to both govern the conduct of populations, and also that of professional 'experts' themselves. Expertise and profession are not synonymous. But, the process of professionalisation, such as that which nursing in New Zealand has participated in

over the last thirty or so years, facilitates the authorisation of ‘expert’ knowledges<sup>30</sup>. In this sense then, rather than being at odds with techniques of rule, the professions are dependent upon government, as government is dependent upon them to govern populations “at arms length” (Rose 1993). This type of governance is very obvious in the ways that health professionals become the conduits for health promotion messages.

Yet authorising professions to govern at arms length involves being able to rely upon ‘experts’ to behave appropriately. Fournier suggests that the way that this is done is by deploying professionalism as a “disciplinary logic which inscribes ‘autonomous’ professional practice within a network of accountability that governs professional conduct [itself] at a distance” (1999: 280). The deployment of this disciplinary logic, the outcome of which is the governance of professional conduct indirectly, or at a distance, involves what Foucault termed technologies of the self. Technologies of the self are means by which individuals govern their own conduct without the need for direct control or intervention. The very act of taking up a professional identity means that the professional is enmeshed within systems of accountability and professional conduct and is thus governed at a distance by means of the notion of professional competence - both the use of expert knowledge and also of appropriate conduct (Fournier 1999).

The tangled way that professions form as part of the state in what Rose calls advanced liberalism positions them complexly as autonomous subjects and:

as an autonomizing and pluralizing formula of rule, it is dependent upon the proliferation of little regulatory instances across a territory and their multiplication, at a ‘molecular’ level, through the interstices of our present experience. It is dependent, too, upon a particular relation between political

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<sup>30</sup> See Bondi (2004) for a discussion of the ways that counselling in spite of moves to professionalise what began as a lay practice, may contest the traditional ‘mapping on’ of an understanding of professional expertise, and it also in fact have the potential to rework the notion of what it means to be a profession.

subjects and expertise, in which the injunctions of the experts merge with our own projects for self-mastery and the enhancement of our lives. This is not to say that our freedom is a sham. It is to say that the agonistic relation between liberty and government is an intrinsic part of what we have come to know as freedom (1993: 298).

Understanding rural primary care nurses to be positioned within the state in this way helps to make sense of the way that nurses govern their own behaviour, beyond simple notions of gendered constraint. Looking at what Rose (1993) calls “little regulatory instances” as I do below, helps to make concrete the ways that nurses participate in technologies of the self that are simultaneously liberating and constraining.

### **Negotiating everyday practices: Confined professional selves**

Part of the constraint that nurses manage is physical. Appropriate professional conduct of rural/remote nurses requires them, among other things, to be spatially self-governing, in that they must remain within the area that they are on-call for. In the contemporary setting the expectation that the health professional be available is made possible by various types of technology in ways that would not have occurred historically in rural health care. In one of areas that I conducted fieldwork I went with the nurse as a non-participant observer for a day. No cell phones worked in the area and the nurse phoned on arrival and departure to and from each location to change the answer phone message at the base clinic so patients would know when to expect to be able to make contact. In regions where cell phones and pagers do not work, which was almost all of the places I visited, one of the ways that nurses may be contacted when they are on-call is by the St Johns ambulance control centre activating the nurses’ car horns. This activation of a car horn would be done for the nurse to respond to an emergency call, not for regular patient needs. Where traditionally cars have been

seen as liberating for women, these cars, which are provided by the employer, carry an implicit constraint. Although this does give nurses some flexibility that allows them not to have to sit by the telephone, it is nevertheless very constraining when periods on-call can last for up to 10 days and nights at a time. Although extensive, the following quotation provides a good example of the encompassing nature of the constraint on both mobility and social behaviour:

*...It's just, it's the fag of having the car so I can't go for a walk. I suppose I've got round that. I go for a walk and stay within earshot and I usually go for a walk at night once my [partners'] home but it means that we can't go for a walk together. He stays home and if the car horn goes off, he brings me the car....so you do develop ways of getting around it and I think too you do learn to relax more. I mean if I want to go and visit friends at night, or we want to go out, within the district. I just take the car with me and we are out. I mean if the car horn goes off I deal with it, I mean obviously you can't drink, but then it's quite funny, I'm not a drinker at all and every once in a while when I know I am not [able to have a drink] I really want one. You know, on my days off I don't drink. When I am working I'll think oh it would be nice to have a couple of wines tonight but I know I can't, and it's only because you know you can't and you want what you can't have, but it really isn't a problem but yeah, you do get more relaxed about making sure that you have a life as well as doing the job that you need to do. Because you are not called out every night, you go through patches. I shouldn't say that, because whenever I say that I get about five or six call outs in a row. But I mean you will get some weeks when you are not called out in the evening, you might have another week where you are out every single night doing something and there is no rhyme or reason to it (Rural registered nurse. 2002).*

Not being able to be contacted and drinking on the job are here identified directly as inappropriate conduct. Similarly, although the following nurse does less on-call work than some counterparts, the nurse's social behaviour is physically constrained by the professional ethic of confidentiality:

*...Yeah and darts. Darts is on a Wednesday night and Wednesday is my on-call night. It's like a conflict for me, I'd like to go and play darts but I don't really feel all that comfortable being there in a loud environment with my pager on and you know, if I get a call, where do I go to answer it privately, so yeah, I find I have to get away a lot and then so you are trying to become a part of the community but there's the tension between the professional role and living life in a bit of a glass bowl. But I do struggle with that (Rural registered nurse. 2002).*

The mutual surveillance aspect of the 'glass bowl', which implies being able to look out at, and to be looked in at, elicits another type of mobility for some of the nurses. The tension between professional and personal needs and expectations is evident in this nurse's response to 'get away', to utilise mobility to 'escape' demands, similarly another nurse said:

*Then on your off-duty time you get away because people come knocking on your door* (Rural registered nurse. 2002).

Yet this desire to escape sometimes sat uneasily with conceptions of appropriate professional conduct that are influenced by the 'shadow of the law'. Incorporated into the ways that nurses govern their own conduct utilising technologies of the self is the shadow of the law as already discussed in chapter four. The expertise embodied in the law sits alongside that of health professionals in the contemporary state, and as a field of authorised 'expertise' it has a significant influence on the ways the health care is carried out in New Zealand. In terms of the discussion so far that has considered the complex spatial negotiations in which rural/remote nurses are enmeshed, law may serve to add an extra confounding factor on nurses mobility. The legal concept of 'duty of care' is used in court deliberations surrounding questions of practitioner negligence.

This legal formulation may at least contribute to the way nursing is enacted in the rural environment, and is particularly evident in the ways that some nurses feel that they cannot leave the area even if they are officially on leave. In noting that the work situation can be hard on families, one nurse said that cover had not been arranged for the weekend which was to be the beginning of a break. Cover did not in fact arrive until late on the following Monday. The nurse felt unable to leave until the

relieving person was there. I asked one nurse, based on what this first nurse had said:  
Is it hard getting somebody to relieve or do you just think, that's not my problem?

This nurse responded:

*You have to think that's not your problem because otherwise we'd be taking on our manager's role, trying to organise relief for ourselves and I think we've got enough in our job really and it's up to the managers to employ relievers.*

LT: Some nurses seem to have quite a lot of trouble getting relievers and have trouble getting away.

*Nurse: Well I don't think that's a good system at all and that's almost like being a martyr if you say, well I don't think I'll have holidays because nobody can possibly replace me or they'll never find anyone to relieve me, and I can't find anyone to relieve myself then it's a rod for your own back really (Rural registered nurse. 2002).*

If a potential misconduct case comes to the courts, decisions are made on a case by case basis and as Tingle (2002: 1128) says the court: "in deciding the issue of a breach of duty of care, would judge the defendant's conduct by the standard of what the hypothetical, 'reasonable person' would have done in the circumstances of the case". Presumably the behaviour of a 'reasonable person' is considered with reference to the context of practice. While this issue is obviously important in clinical terms, it is also important with regard to the issue of practitioner availability and begs the question as to whether rural nurses owe a duty of care if they are not on-call but are presented with a patient at their door.

The above nurse draws, what is essentially a line in the sand, accepting no responsibility to stay, or organise cover. The enculturation which occurs in the training of professionals interpellates them as 'responsible', thus there is a level of trust that they will not just walk off the job. It is also possible that a fear of litigation reinforces what may be perceived as 'martyr' behaviour, and this is not without

foundation, nor confined to nurses as the following example illustrates. A rural doctor was disciplined for not attending a patient experiencing chest pain at the local bowling club while the doctor was not on-call (the patient later died). Another doctor was on-call for the area, although was not in as close proximity as the first doctor (Alchin 2003: *pers comm.*). In medico-legal terms the issue of practitioner availability is complex. Indeed, it raises the question as to whether a rural nurse (or doctor) can ever be perceived to be off duty. What on the one hand can look as if the nurse thinks that s/he is indispensable may in fact be a much more complex interplay of various discourses of appropriate behaviour governed by the shadow of the law, professional enculturation and personal notions of where the limits of responsibility lie. Altogether these factors contribute to the technologies of the self that nurses deploy to govern their own behaviour, but the outcome of negotiating the unclarity of on or off duty and what responsibilities that incurs often chases nurses out of their homes. Conceptually no local physical space is perceived as 'non-work' space, therefore the ability to take on a non-work identity is extremely constrained.

#### Duty of care and ethics of care

The difficulty experienced by nurses in feeling as if they are really off duty may contribute to the desire to leave the area when they are not on-call. Perhaps they feel that they are safe when they are actually out of the area from potential accusations of not fulfilling a duty of care. And more than the duty of care being simply a legal technique, it can also be argued to dovetail with gendered notions of responsibility for care, which comes into the realm of the 'ethics of care' as a philosophical concept.

Those proponents of an ethics of care argue that the moral reasoning of women differs from that of men. They suggest that in contradistinction to the ways

that men make moral judgements, women are more likely to be, as Gilligan, argues, orientated “towards relationships and interdependence” and that “this implies a more contextual mode of judgement” (1982: 28).

If caring is more likely to be the province of women, as Gilligan argues, then the positioning of men within nursing, which has long been thought of as a caring profession, quite obviously raises questions about either the nature of nursing or Gilligan’s formulation. Gilligan does not say that no men are caring, or that all women are. Perhaps it is sufficient to say that those men who are drawn into nursing for one reason or another become part of a profession that has an ethic of care. But the ethic of care is played out in particular ways in rural places.

Both men and women relayed incidences where they were torn between a feeling of responsibility for providing care and needing time out and off from both their work and their community. For instance, the following nurse “feels like the witch” when patients are turned away on days off. This situation is made quite complex for nurses who are aware that the next nurse or doctor may be forty-five minutes or an hour away. The tension of being in the vicinity but not on-call is clear in this following transcript:

*Ultimately it would be fantastic for me if someone actually relieved my days off because invariably the phone goes on Friday night or, in fact someone turns up on my door even though I’m not on duty and it’s very difficult in the face of it to say, “hey, I’m not on duty, you’ll have to ring the [nurse in the other centre]”, you feel like the witch, yet on the other hand if I don’t catch my breath you get into the next period feeling that little bit more tired about the whole workload – routine and call. And I believe my family need to have me as their priority for three days a fortnight. It’s quite reasonable to put them ahead of my workplace for that period (Rural registered nurse. 2002).*

The above transcript also draws on notions of appropriate conduct in relation to being available for the family. This nurse’s partner had recently expressed annoyance at what were felt to be excessive demands the work placed on the nurse, and by

association the family. Tension between professional and personal identities gives rise to a strategy of 'splitting' in order to accommodate both identities.

### Splitting identities

Those nurses who do not use 'going away' in their off-duty time as a means of escape use various techniques to attempt to insulate themselves from the microspace that is their community. Although the following nurse feels more off-duty when not in the community, moving within the community to a less obvious and accessible house has helped:

*We've got family in [another region], so it's good to catch up and get out and at times you do feel like you're more off duty if you're not here. I think though being situated where we are now I feel more off duty. I felt a bit more exposed when we lived on the main drag. It was a bit easier, people knew you were home so they would ring and they would go, "oh but could you ...?", and it wasn't that you had to deal with it because you could say, "oh no, you need to ring..." but it still interrupted that blob time of just, I'm not working and, you know, sometimes by the time you had gone through the explanation you sort of thought well I might as well have dealt with it. But then you think, no, no, that's the wrong thing. It's an education process. They need to know. The kids are really good, if it is my weekend off, my kids are really good at answering the phone and they'll say, do you want to speak to [parent] or the nurse? 'Cause if it's a local they don't know if they just want to chat to me because there's something going on or whatever. So the kids will say, do you want to speak to mum or the nurse? And then they will say, well [parent's] off this weekend, you need to ring... so that's quite good (Rural registered nurse. 2002).*

This nurse draws a distinction between the public and the private and the nurse's family splits personal and professional identities in order to insulate the nurse from public intrusion into private time and space. The following nurse also splits identities in order to separate public and private worlds.

*If anyone asks me anything out of the clinic I usually say to them, I'm not working today, I'm [own name] today. If you need to discuss this you need to ring [the other nurse], ring the clinic or ring me on a day I'm working (Rural registered nurse. 2002).*

For those who are unable or unwilling to leave the area when they are not on-call, a process of overt identity splitting insulates to some degree from inappropriate demands, although this splitting is never completely effective or without some emotional cost in the form of feeling that patients may feel let down.

While not completely unique to rural health care, the need for insulation from one's professional identity is not such a large part of urban practice and neither is the need to constantly negotiate boundaries around appropriate conduct. Although urban nurses must, of course, reflect upon appropriate clinical conduct, the boundaries are often much clearer with the physical proximity of other health care providers with specialised roles.

It is important to remember that although rural primary care nurses negotiate boundaries that are often unclear and often difficult, many have 'chosen' to be there. Exercising autonomy through resistance to the centre (moving to the periphery), in some sense involves exchanging focussed, but episodic surveillance as may occur for a hospital nurse, for the continuous gaze of the community and its expression through duty of care and appropriate behaviour. Nurses' governance of appropriate conduct is not clear-cut and unambiguous. It seems that it is a continual struggle to negotiate clearer boundaries. Rural nursing work, at least to some degree, escapes the bounds of the workplace and spills over into off-duty time. Conceptually and professionally, rural/remote nurses are self-governing, but mobility is used as a means of escaping the all-encompassing nature of the demands of their work for constant decisions regarding appropriate conduct.

### **Concluding Comments**

Simple notions of geographical mobility have been seen as one of the desirable features of the contemporary worker. But the mobilities exhibited by rural primary

care nurses are vastly more complex than simple geographical mobility, although this geographical mobility is not unimportant since the acknowledgement that just under half of the nurses had moved to rural areas specifically for the nursing work available there, in spite of the constraints, both contests a simple spatial entrapment thesis and also provides evidence of the willingness of at least some people to relocate to rural professional work. Some understanding of the reasons that nurses might wish to practice as rural primary care nurses is needed in order to assess the potential for the expansion of comprehensive models of rural practice into non-rural settings.

My initial assumption that the nurses who participated in this study were rural women dependent upon rural labour markets was only partially true for some few nurses. Thus complicating the arguments in the literatures regarding women, work and mobility that have generally found women's work to be fairly spatially constrained insofar as women tend to work closer to home and are less likely to relocate for the purposes of their work. While I do not doubt that women's work is still relatively spatially constrained in the ways indicated in the literature, there is space for exploration of cases that contest notions that tend to generalise as Gilbert (1998) pointed out.

Nurses who had relocated to rural areas specifically for the nursing work drew on discourses of autonomy and independence to explain their decisions to relocate. These relocation decisions were constructed as in some sense resistant mobilities insofar as nurses move from fields of nursing practice where they felt that they were not delivering the type of nursing that they wanted to. Thus the rural was perceived as space of relative freedom in clinical practice terms.

Within this space of freedom, on-call nurses' jobs were extremely spatially constrained in that nurses could be tied to a confined geographic area for up to ten

days at a time. Making sense of the trading of focussed but episodic surveillance as may occur in the hospital, for a more comprehensive and apparently endless surveillance was puzzling. By understanding the way that the professions form and operate in the contemporary state using theories of governmentality focussed mainly on technologies of the self, the trade can be seen as a shift in type of power and control. In the hospital there is a more direct form of control, although nurses still govern their own clinical conduct to a large degree. In the rural, as indicated in the previous chapter, a particular type of surveillance space is constructed within which nurses must govern their own practice on a microscale.

The flexibility of rural nurses in clinical, temporal and spatial terms initially suggested a highly gendered adherence to notions of meeting need, and dependence on limited rural labour markets. But, constructing the nursing self as autonomous and independent shifts the power/control balance in ways not possible in close proximity to other practitioners. That is not to say that nurses were/are free to do anything that they please in rural health care, it is to say that they assume more control over the everyday negotiations surrounding appropriate clinical and social behaviour. Whether this control could be maintained should these models of care be attempted in urban settings is an open question, the answer to which probably relies upon the employment structures into which the nurses are inserted.

Analysis of the everyday practices of rural nurses shows the complex and interwoven techniques and technologies that are used to construct notions of appropriate behaviour. These techniques and technologies are drawn from professional ideology, individual understandings of appropriate conduct and legal discourses, such as the duty of care.

Mobility was used both to move to work that they wanted, and to escape from the demands this work placed upon them. This chapter extends the debate on women, mobility and work by paying attention to the complex spatial negotiations that are carried out in doing profession and place. What nurses have deployed as resistant (mobile) behaviour is read here ambivalently, using Foucauldian understandings of governmentality in order to attempt to make sense of how nurses appear to confine themselves and perform in self-governing ways even in so far as they perceive themselves to have moved to the borders of surveillance.

Freedom then, is always contingent on the exercise of power. Perhaps this is what the nurse meant who said that although there was freedom to be autonomous and independent in rural/remote nursing, that this is always constrained within the bounds of what “the establishment” says about how to be a nurse. In order to make sense of high levels of spatial constraint and negotiate cycles of professionalism, invasion and escape that nurses experience when they are on-call they must utilise some competing discourse, or sacrifice a degree of coherence in their social and professional identities.

Moving to rural work as a way of gaining autonomy to practise in more self-defined ways appears to be one of the key factors influencing those nurses who had relocated for rural work. This factor in itself indicates a strongly held sense of professional identity that is not easily satisfied in other health care settings. Although the nurses who participated in this research may be relatively unusual in clinical terms, the sentiments they express about wanting more control over how they perform as nurses are not (see Coombs 2005). In a previous study (Thompson 2001), I found that small-town hospital nurses also expressed discontent at the lack of fit between the institutional constraints around their practice and their own perceptions of what that practice should be. With the continued shift to a focus on community care rather than

institutional hospital care, perhaps this ‘lack of fit’ can be harnessed to encourage nurses to think in terms of different types of practice in which they may have more control over their practice, while always understanding that with less external control over work, comes more internal control in the form of technologies of the self as this chapter has shown overtly. The self governance the rural nurses engage in was also obvious in the ways they manage risk, trust and law.

The following chapter begins the third and final section of the thesis. The task of this final section is to investigate what might be needed for the model of rural health care, critically analysed in the previous chapters, to expand into the urban setting. There are two parts to this investigation, the first is to use a satellite study to examine what happens when a newly developed nursing role, designed to meet the needs of rural communities is attempted. The Family Health Nursing role, initiated by the World Health Organisation is one such role and was designed to meet the needs of rural communities by providing a generalist nurse as the first point of contact in the health care system. This role has been introduced in an intentional way in Scotland and this introduction is explored in the next chapter. The second chapter in this section takes up the theme repeated throughout the thesis so far; that of the low levels of understanding of nursing in general and generalist nursing work in particular in the increasingly specialised world of health care. This chapter examines the need to develop a ‘language’ of nursing that is understandable to policy makers, the public and other health care professionals.

**Taking Governed Professional Selves ‘Out of  
Context’**



## **Family Health Nursing: Examining an Intentionally Constructed Generalist Nursing Role**

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### **Introduction**

In the previous chapters, by exploring the everyday practices and professional identities of nurses, I have been building an argument that the model presented by rural/remote nursing in New Zealand has a great deal to offer primary health care in general and has the potential to expand beyond the rural. In the absence of direct proximate governance, nurses govern their own practice and selves in ways that render them ‘reliable’, and ‘safe’ deliverers of comprehensive primary health care that offers simultaneously more and less than medicine.

I was curious to know if this type of generalist nursing role had been used anywhere else in contemporary health care. While I am fully aware that extensive use is made of generalist nursing roles in outback Australia and rural and remote areas of Canada and the United States, these are adaptations of existing nursing roles much as is the case in New Zealand, that have grown up around the contingencies of place. In the European Union there has been a very interesting development in the attempt at an intentional construction of a generalist nursing role, the Family Health Nurse (FHN), instigated by the World Health Organisation (WHO) Europe, and designed to be the first point of contact to the health care system.

An investigation of the introduction of the generalist FHN role allows for an understanding of the challenges associated with the introduction of a new nursing role. In theoretical terms the instigation of the new nursing role presents a very messy space in which discourses are both unclear and emerging at the same time. This state of discursive flux is evident in the ways that nurses talk about their work. In the context of the Western Isles, FHNs spoke of conflict within their own professional identities and between FHN identities and other nursing roles, while there appeared to be little overt conflict with medical identities. The conflictual nature of these professional identities raises questions about the ways in which new performative identities achieve some degree of coherence.

This chapter draws on data constructed from interviews with FHNs in one of the sites in Scotland that piloted the new nursing role. The chapter is divided into five parts. The first provides context to both the development of the FHN role by the World Health Organisation and the also with the context of Scottish health care. The second section deals explicitly with the pilot of the new role. The third section draws out the issue of professional boundaries as they are worked out in the newly introduced role. While there is little in the way of role conflict between FHNs and doctors, of more importance are the intrprofessional boundaries that nurses negotiate. The particular focus of FHN work, as it has been taken up in the Scottish context, on families and health promotion is critically addressed in the fourth section. The ways that individual nurses and FHNs as a group come to be made auditable subjects (Surtees 2003) in order to attempt to justify their positioning within contemporary primary health care in Scotland is the subject of the final section. Concluding comments are made about the potential for and complexity of the expansion of the generalist role beyond its current reach.

### **Context: The development of the FHN role by the World Health Organisation**

For nearly twenty-five years the member states of the World Health Organisation's (WHO's) European region, in spite of their many differences, have attempted to embrace a common framework for health policy development. Goals identified by WHO Europe include universal access to health services that are based on scientific evidence, that are affordable, of good quality and are sustainable (WHO 1998: 5). Amongst the key targets identified by the WHO, is a shift in focus that involves greater integration of the health sector and a much stronger emphasis on primary health care.

The shift in focus towards primary health care is part of a global move towards prevention rather than simply a focus on cure. This shift has been stimulated by the belief that there has been too much attention paid to what has been called an illness model that paid particular attention to hospital care and medical care. Prevention of as much ill health as possible has become the key area of concern. Several documents have been fundamental in this shift in focus; namely, the Alma-Ata Declaration, (WHO 1978). This declaration stated that there was an urgent need for "action by all governments, all health and development workers, and the community to protect and promote the health of all people of the world" (WHO 1978: 1). Following on from this document, the Ottawa Charter for Health Promotion (WHO 1986), indicated the need to reorient health services so that they might move beyond responsibility for clinical and curative services, towards health promotion. This shift focused around the need to reduce the economic and social costs of the 'burden of disease'. In recognition of the complexity of any effort to reduce the burden of disease, an integrated approach was proposed, encompassing health promotion, disease prevention, clinical treatment, and rehabilitation (WHO 1998: 17).

While acknowledging that in many countries there has been an intention to reorient health systems towards primary care, the emphasis has frequently remained with curative care, while health promotion, disease prevention, and rehabilitation have received less attention (WHO 1999). Traditionally clinical patient care and public health have been seen as separate enterprises (see Curtis 2004 for a discussion of bringing public health to the local level). Within the shift in focus, health outcomes become the point of reference, and to achieve the best outcomes, WHO argues for an integrated philosophy within which health promotion, disease prevention, diagnosis, treatment, rehabilitation, care, represent a continuous linked process to improve health gain.

While it is possible to provide this holistic form of primary health care with a multidisciplinary team, such as those that are desired in Primary Care Organisations in New Zealand (*The Primary Health Care Strategy* 2001), it seems that WHO is arguing for a more fundamental philosophical shift, whereby practitioners are to be professionally prepared in ways that reflect this shift in thinking (see also *European Foundation for the Improvement of Living and Working Conditions* 1991). Intervention at the point of professional preparation challenges traditional models of education that have, or at least assisted, in erecting and reinforcing disciplinary boundaries that do not stretch to the larger, more encompassing view that WHO deems essential to work towards the best health outcomes.

WHO's European office identifies the practitioner at the centre of this newly focused, broadly-based primary care provision as, "a well trained family health nurse, providing a broad range of lifestyle counselling, family support and home care services to a limited number of families" (WHO 1998: 25). The Family Health Nurse (FHN) has been developed in order to address some of the perceived shortcomings in

primary health care delivery across the European Region. These shortcomings include difficulty with access to services particularly in underserved areas and poorer regions of the European region (WHO 1998), the problematic nature of delivering services in rural and remote areas, and the continued focus on tertiary care often at the expense of primary care (ibid). Access to health care is one of the key issues in rural and remote places and it is partially this factor that prompted the setting up of the concept of the FHN. In a report on health care in Europe, the three-fold objective of access to care for everyone, a high level of quality in the care that is provided and the financial viability of health care systems, is identified as the challenge to be met by the members of the European Union (Commission of the European Communities 2001: 4).

The FHN is essentially a generalist role that contains elements that are already part of several different types of community nursing roles in primary care in Europe. This FHN, as recommended by the Vienna Conference on Nursing in 1988, is seen to be a key Primary Health Care professional who can make a very substantial contribution to health promotion and disease prevention, besides being a caregiver (WHO 1999). Within this model of primary health care, the family health physician would provide more specialised services, while both the family nurse and doctor would interact with local community structures on local health problems. Citizens should be free to choose which practitioner to use, while both should support patient self-care (ibid). The FHN role was envisaged as one where:

Family Health Nurses can help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection, they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family's health and

refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise (WHO 1999: 139).

Over against the ad hoc nature of the development of the generalist rural/remote nursing role in New Zealand, the WHO's European Office took up and promoted a generalist nursing role, the FHN. In the original intent of the FHN role it sounded remarkably similar to the roles that the rural and remote nurses in New Zealand were carrying out. Eleven interested countries<sup>31</sup> began as pilot sites of the FHN role, but interestingly, only the pilot carried out in Scotland appears to have had marked success (WHO 2003b). The main reason for that lack of success with the majority of the other twelve pilot sites was due to lack of government support (WHO 2003b). Four pilot sites were set up in the NHS areas covering Highland, Orkney, Western Isles, and Argyle & Clyde.

While the initial intention of the new nursing role was to position the FHN as the first point of contact in the health care system, in much the same way that nurses in rural and remote nurses are in New Zealand, how the role has been taken up and the everyday practices of FHNs have not borne this intention out. The positioning of FHNs within the Scottish health care system, against the initial intent of the role, highlights the way that nursing roles will be taken up in place in different ways. Roles are not mapped on to places but are differently performed through place. Further, even within the relatively small geographic area of the Western Isles, the site in which the participants whose data are considered in this chapter are located, FHN roles differ quite markedly in some cases.

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<sup>31</sup> Countries involved in the pilot project were: Armenia, Denmark, Finland, Germany, Kyrgyzstan, Lithuania, Republic of Moldova, Slovenia, Spain and Tajikistan, as well as Scotland.

### **Scottish health care context**

The philosophical shift to a focus on health, rather than illness, has been enthusiastically taken up by governments worldwide (see NHSScotland 2000), perhaps predominantly because it appears to be a needed tool (albeit a comparatively long-term one) to reduce the burden on governments in the provision of health care and also to protect the health of citizens enabling them to be more 'productive' members of society. The impetus for taking up the shift to prevention has come from the understanding that there are long-term savings in health care expenditure to be made by attempting to keep people well and that there are things that can be done to intervene to facilitate this process. The focus in health care policy circles has shifted from the hospital sector on to the primary care sector. The primary care sector is the first point of contact within any health system and is thus the key point at which a patient may be 'captured' for health monitoring and educated in issues such as lifestyle change.

The contribution of nurses to the delivery of health care has moved to a more central position on the agenda of governments and this is evident in such Scottish government publications as *Nursing for Health: A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health* (2001) and *Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland* (2001). Alongside these reviews of nursing, midwifery and health visiting, the Scottish government has produced a general health strategy that acknowledges the importance of the role of nurses in the provision of primary health care.

There is increasing attention to the issues of provision of health services in rural and remote areas in contemporary government policy in both Scotland and New Zealand. Within nursing policy, there is explicit focus on the special need for

provision of health services in rural and remote communities. Issues of ‘equity’ and ‘need’ are used as justifications:

Increasingly, Nurses and Midwives are also responding to people’s needs by developing services with new patient groups and in new settings. People living in remote and rural areas, for instance, who may have difficulty accessing conventional medical services, are finding Nurses and Midwives plugging the gaps (*Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland 2001: 9*)

Interestingly, the phrase ‘nurses and midwives plugging the gaps’, resonates with the New Zealand nurse who said “I’m sick of being seen as a stop-gap”. Where in *Caring for Scotland* (2001) nurses are constructed as flexibly providing their skills where needed to meet patient need, the New Zealand nurse finds this type of construction offensive with its connotations of being a temporary solution to the problems of access to health care in rural places.

### **Family Health Nursing: the Pilot**

A pilot project ran from 2001-2003, with FHNs remaining in post as employees of various health boards. Since the aim of the WHO Family Health Nurse Project (FHNP) was to introduce the concept and then pass the implementation of the role on to member countries, WHO Europe had limited influence on how this was done, although WHO Europe did formulate a curriculum for the training of FHNs. For the role to be taken up at all it needed to be endorsed at member state ministerial level and this has been a barrier in a number of the countries. The success of the Scottish experience has been attributed to careful planning and adequate funding, with a budget of £1.3 million being allocated to study leave for the 31 nurses who were already National Health Service employees to enable them to attend the education and training programme at the University of Stirling for the Family Health Nurse role. The original sum also included the Project Officer’s costs and the research evaluation.

The FHN curriculum in Scotland is a hybrid, bearing elements from Family Health Nursing in North America as well as ideas from WHO Europe. The new curriculum has also had to meet the requirements of what is now called the Nursing and Midwifery Council<sup>32</sup>, the regulatory body for nursing, midwifery and health visiting. The particular way that the FHN curriculum was developed in Scotland differed from specialist community-based education for nurses, midwives and health visitors, and also from the WHO curriculum. It did not include modules on quality issues, teaching and supervision, management or leadership, but was more focussed on its speciality which was grounded theoretically in nursing ideology combining elements of FHN from North America and ideas from WHO Europe (Macduff and West 2003: vii).

The reasons for the implementation of the FHN role in Scotland appear to be threefold. Firstly there was a desire to decrease fragmentation in health care provided by nurses due to the large number of already existing community nursing roles. Gaining commitment to the FHN concept in Scotland presented some challenges, since there were already eight nursing disciplines providing a range of community-based nursing services (*WHO* 2003b: 2). This large number of community nursing roles has the potential to lead to fragmented, and probably in some cases, overlapping services. The Scottish Executive<sup>33</sup> endorses the need to streamline the routes into community nursing with the current number argued to be unsustainable and not in the best interests of the profession (*Nursing for Health* 2001: 37).

Secondly, there was a desire to introduce this generalist role as an attempt to deliver more targeted health promotion as a means of addressing the government

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<sup>32</sup> The Nursing and Midwifery Council (NMC) was previously called the UKCC.

<sup>33</sup> In 1999, the Scottish Executive and Parliament came into being having been previously administered from the United Kingdom government in Whitehall. Some of the areas that were devolved to the Scottish Parliament were those of health and social work, tourism, the environment, and economic development.

commitment to improve population health. The Scottish Executive promoted the role as being, among other things, “a skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required” (Macduff and West 2003: 46). While Kesby (2002) saw the FHN role as being on equal footing with the general practitioner, this does not appear to have been the way that the role has developed in Scotland (Macduff and West 2003).

Thirdly, the role was seen as “a potential solution to some of the problems of providing health care in Scotland’s remote and rural regions” (Macduff and West 2003: vi). Presumably this potential contribution to rural health care was due to the broad nature of the role in its original intent, which would obviate the need to provide many discrete nursing roles when this one would suffice. In a professional climate marked by increasing specialisation in nursing in the community, a generalist role could thus potentially help to address some of the skill shortages identified where many different specialised community nurses were needed to cover health care needs. In parts of rural and remote Scotland ‘triple duty nurses’ have provided primary health care cover. The triple duty nurse is one whose job combines three distinct traditional professional roles. In remote and rural Scotland the usual combination has been district nurse, midwife and health visitor. It is becoming increasingly difficult to sustain the traditional double<sup>34</sup> and triple duty roles (Macduff and West 2003).

Of particular relevance for the purposes of this chapter are the already existing roles of roles of district nurse, and health visitor. The district nursing role is very similar to that in New Zealand where these nurses are employed by local health boards or Trusts and they are responsible for working with patients and their carers in

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<sup>34</sup> A nurse whose job combines two distinct professional roles. In remote and rural Scotland these would traditionally be district nurse and midwife; community staff nurse and midwife; or district nurse and health visitor (Macduff and West 2003: ii).

the community where they assess healthcare needs and develop appropriate packages of care. The traditional health visiting role is very similar to that of a public health nurse in New Zealand with a focus on the promotion of health and prevention of illness in all age groups. The FHN was being piloted at a time when it has been suggested that the roles of FHN and public health nurse (an amalgamation of the previous roles of school nurse and health visitor) be the only two routes into community specialist practice (Nursing for Health 2001). In the Scottish case the FHN role encompasses parts of current district nursing and health visiting. The Scottish Executive argues that: “although differences exist across Europe in the delivery of primary care, there is universal agreement that primary care must be the core of service provision and that provision of medical and nursing services based on specialism is unsustainable in the long term” (*Family Health Nursing in Scotland: A report on the WHO pilot: 2003: 4*).

In the preliminary report to WHO on the Family Health Nurse Project it was indicated that eleven different ways of practising had been identified which, it was argued, highlighted the flexibility of the role. “Examples of practice models included: the FHN as a single practitioner working on an island or in a remote inland area with other specialists some distance away, who is multi-skilled and maintains strong links with specialists and the FHN in a nursing team” (WHO 2003b: 3). All of the nurses who participated in this research were part of teams rather than sole practitioners. There have been substantial benefits involved for nurses who took up the FHN training.

#### Family Health Nursing in the Western Isles

The physical, geographical context within which the FHNs who participated in this study worked, would be considered remote, or at least peripheral in United Kingdom

terms. The island chain of the Western Isles has an (ageing) population of about 27,180. There is one town, Stornoway, with a population of about 9,000 (see Figure 1.2). The town has one 212 bed hospital, as well as two medical practices. Scattered around the islands are twelve general practitioner dispensing clinics/surgeries. All FHNs in the Western Isles are employees of the Western Isles Health Board and work from already existing clinics and surgeries. Release monies were paid by the Scottish Executive to the Health Boards to provide nursing cover while nurses were completing the Family Health Nurse course, and nurses continued to receive a salary while they trained. Nurses also received support in terms of travel and accommodation when they had to attend on-site blocks of lectures. A similar degree of commitment has been shown in New Zealand recently with the introduction of scholarships for rural nurses (six per year) to enable them to be released on pay from their current jobs to complete Clinical Masters degrees. In most cases in the past nurses have continued to work at their usual employment and have fitted study commitments around this employment.

Although I have argued elsewhere in this thesis that at least some of the New Zealand rural primary care nurses do not necessarily fit with arguments about the confined nature of work opportunities for rural women (see Little 2002), the Western Isles nurses did draw on notions of (gendered) labour market constraint to partially explain why they were attracted to the opportunities presented by the FHN training. Participating in the FHN course provided nurses with some significant benefits and a degree of career mobility in place:

*Prior to being a family health nurse I was community staff nurse and midwife and I had been in the post for maybe about 12 years or so and so the next step up in order to get a kind of team leader, or that type of post was to either do a District Nursing Certificate or to remain working in the community, possibly health visiting or something. Because I have a young family, you know, it's difficult to do that especially because you would have to go to the mainland to*

*do that kind of thing. So this opportunity came up ... for the family health nursing, so it's just too good an option to miss out on basically (Family Health Nurse 2004)*

In all but one case (where the nurse was already at G Grade<sup>35</sup>), doing the FHN course gave nurses the opportunity to benefit professionally and financially; opportunities that would not have otherwise been open to them, due to the lack of advanced nursing posts available locally. On graduation as FHNs, nurses are at G Grade on the nursing ladder and also gain Bachelor of Nursing<sup>36</sup> degrees on completion of the course.

*I did it because it was open to Staff Nurses and we were guaranteed a G grade at the end of it. Which I thought, well it's one way of moving on. So I did it. I knew that I probably wouldn't be working in the same place when I came back (Family Health Nurse 2004).*

The above nurse did in fact move to a different workplace on finishing the FHN course, but she did not have to relocate to do the new job. Nurses were aware of the FHN course as an opportunity to advance, or in the case below, for gaining lost ground in terms of professional career development. But, because of the limited local labour market for nursing, there was also the ever-present anxiety about returning to study after, what for many, was quite a long break.

*Our Director of Nursing put out a questionnaire wanting to know if anybody was interested in doing family health nursing. As I had only recently come back in the district having been years away, I felt it was a chance for extra studying and getting me back properly into the way of nursing in the community again. And also, to be fair, it was a chance of getting a higher grade and, like I had been used to before I went into the hospital to work. And that's ultimately how it happened. I also felt, I said this to you already, that being the first cohort, in the first cohort of family health nursing, I felt there was a good chance that they wouldn't fail us, but that I had some chance of passing the programme (Family Health Nurse 2004).*

As well as a being a challenge in terms of returning to formal study after many years away, the course, for most nurses, also embodied a shift in focus in their nursing work towards a greater attention to the promotion of wellness rather than the treatment of ill

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<sup>35</sup> Registered nurses in the United Kingdom are graded from D to H, with D the most junior and H the most senior.

<sup>36</sup> Many nurses trained as registered nurses before nursing became a degree programme.

health. This shift has two consequences, the impacts on professional and inter and intra professional boundaries, and on the implications of promoting wellness. This later point will be explored later in the chapter.

### **Professional boundaries**

Inserting a new nursing role into an already well-stocked pool of nursing titles has been problematic. In the following quotation the practice nurse referred to works predominantly within the surgery, the district nurse visits people in their homes and does dressings and general domiciliary health care, and the health visitor focuses on health promotion in the community and in some cases in schools, but not in as comprehensive a format as does the FHN:

*Well you've got your practice nurse, you have got your district nurse and you have got family health nurse, you've got your health visitor. I feel people just don't really understand (Family Health Nurse 2004).*

It is not a simple matter to merely insert a new nursing role and have it adequately understood by other nurses, managers, and doctors. The particular way that the FHN role was introduced had at least the potential to lead to conflict and misunderstanding. While many new developments are driven from 'below', the FHN model was introduced from 'above'. Rather than nursing groups identifying a need for the generalist nursing role and lobbying for its introduction, decisions were made at the level of the Scottish Executive about the introduction of the role:

*it was something that was pretty well, it was, I suppose you could say imposed rather than everybody got together and said, now we're thinking of this new role and what do you think? They just said, this is happening and we want volunteers immediately (Family Health Nurse 2004).*

On completion of the FHN course, most of the Western Isles nurses returned to their original places of employment and this point may have contributed to the difficulties

that 'others', particularly other nurses and doctors have in understanding the nurses new roles. In chapter five I explored the issue of interprofessional boundaries between medicine and nursing. The way that the FHN role has evolved in Scotland is one that attempts to consolidate nursing practice broadly speaking around public health, and issues of prevention and health promotion. While doctors provide lifestyle advice relevant to specific medical conditions, the reach of the FHN role is far more broad than reacting to a presenting problem, say heart disease that a doctor may give individualised lifestyle modification advice on. Thus the focus on health promotion and preventative measures presents little direct and immediate threat to medicine. The other ways that interprofessional tension emerged in the New Zealand context were those of nurses taking on what was perceived to be general practitioner work and prescribing.

One of the key differences between the nurses in the Western Isles and those in New Zealand, is that none of the nurses that I spoke to did first on-call work for emergencies or general practice (medical) work. Hence they were not perceived to be in competition with general practitioners, although some nurses did on-call work for district nursing. While I was visiting the Western Isles in February 2004, it was announced that the requirement for general practitioners to provide after hours cover would cease. Consequently I asked the nurses if they thought that the ending of the GP after-hours cover would have any impact on their work. Most thought that it would not. In February it was not clear how the after hours would be covered. During my second visit it became clear that the Health Boards had assumed responsibility for after hours cover and were employing GPs to do this and that patients had been instructed to ring NHS24 in the first instance. NHS24 is a telephone triage and healthcare advice system, much like New Zealand's Healthline. The general

practitioners who had been on-call (employed by the Western Isles Health Board) during after-hours had not found themselves to be very busy, but the on-call doctors are paid very well and the system is expensive (Busbridge Pers. Comm. 2004). Anecdotally, some nurses thought that calls to the paramedics (ambulance via 999) had gone up.

A further area where nurses in New Zealand are in potential conflict with doctors, as was highlighted in chapter four, is that of nurse prescribing. The situation in Scotland is a little different with nurse prescribing for district nurses and health visitors being piloted in England in 1994 and this was followed by its introduction in other UK countries. The necessary legislation to enable community nurses in Scotland, with either a district nursing or health visiting qualification to prescribe independently from a limited formulary<sup>37</sup> was passed in 1996. Implementation of the scheme was phased, and by 1999 preparation for prescribing from the Nurse Prescribers' Formulary had been included in the district nursing and health visiting pathways of specialist practitioner and so prescribing is now "integral to the role of all district nurses, health visitors and the small number of practice nurses who have successfully completed the requirements of either the stand alone or integrated course ....There are about 3000 nurse prescribers in Scotland today" (NHSScotland 2002: 1).

In 2001 it was announced that nurse prescribing would be extended to more nurses and to a wider range of medicines, to cover four broad areas of practice: minor ailments, minor injuries, health promotion and palliative care. Nurses who are trained to prescribe under these terms are not confined to district nurses and health visitors, but all nurses who wish to prescribe must, of course, complete the specific programme of preparation for extended nurse prescribing approved by NHS education

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<sup>37</sup> A formulary is a listing of medicinal drugs with their uses, methods of administration, side effects and contraindications.

for Scotland. These nurses will prescribe from the Nurse Prescribers' Extended Formulary. Current nurse prescribers (district nurses and health visitors) may update their training to be eligible to prescribe from this formulary (NHSScotland 2002: 3).

It seems, however, that nurses cannot simply choose to do training and become prescribers since in discussions of funding, it is indicated in NHSScotland: 2002: 5) that:

central funding will be made available to train nurses in prescribing. This will be allocated on the basis of named lists of nurses Trusts have prioritised for training. The Scottish Executive will also take account of remoteness and rurality issues when allocating funding.

If there had been antagonism, as there is currently in New Zealand, to the introduction and extension of independent nurse prescribing then it has largely abated. The different employment structure of nurses in Scotland could at least partially account for this since nurses are not employed by the doctors, and doctors and nurses do not compete for patients since neither the doctor or the nurse are paid by the patient. How useful prescribing is to nurses is variable and depends largely on where they work, since a lot of Family Health Nursing work is carried out in patient's homes. Patients have to go to the town or the nearest dispensing surgery<sup>38</sup> to fill the prescription anyway:

*What is the use of writing a prescription here when they have got to come to a GP practice* (Family Health Nurse 2004).

But, FHNs who had done the training to be nurse prescribers all felt that the knowledge was extremely useful anyway even if they never prescribed, simply because it increased their knowledge of drug interactions and side effects. All the nurses found this extra knowledge invaluable in their practice. Also, for items such as dressings that many of the nurses used on a regular basis, prescribing saved them time

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<sup>38</sup> Surgeries at some distance from the town have the facility to dispense drugs from their premises.

in that they did not have to get a prescription from the GP for the dressing before they could take it to a patient to apply. Having identified little in the way of role conflict between FHNs and doctors, the situation is not so clear cut between nursing disciplines.

#### Intraprofessional boundaries

In the everyday practice of their work FHNs come into contact with ‘other’ nursing disciplines and it is perhaps these that present nurses with their most regular challenges. These challenges are on two levels; one is between individual nurses, and the other within the one FHN, who may feel conflict about how she performs the FHN role in the light of the other nursing identities that she holds currently or has held previously. Uncertainty and conflict over intraprofessional boundaries, and individual professional identity performance and understanding are unsurprising given the ‘newness’<sup>39</sup> of the role and its rapid introduction. Following a recommendation arising from the evaluation of the FHN pilot towards the end of 2003 (Family Health Nursing in Scotland 2003), a facilitator was recruited to assist in the implementation of the FHN in the Western Isles. Part of the goal for this role was to “work with whole primary health care teams in order to support change and develop the full potential of Family Health Nursing within the team” (ibid: 24). In general terms the presence of the facilitator has been a very positive development for the nurses:

*I think it's beneficial the way she helps us. I mean we do get together more often and share experiences and do these workshops and everything and certainly it has been good to have her, because she's just given you that extra lift and, you know, you're doing well. And you feel that, you know, it's two steps forward and one back. Certainly her being there, I feel we needed that* (Family Health Nurse 2004).

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<sup>39</sup> Although the role is constructed as a ‘new’ one, one nurse felt that much of what they learned in the course was revision.

The nurses who have been able to more fully enact the Family Health Nursing role are those located in Stornoway, where due to the skill mix of the practice from which they work, they are able to focus solely on FHN work. These nurses have been able to reinsert themselves into the practice team with a new professional identity, but as the nurse above noted, this has not been a simple process. The advocacy that the facilitator provides is very important to sustaining the new professional identity.

Unsurprisingly, the FHN roles vary geographically, with nurses in smaller and less well staffed areas not being able to perform the FHN role fully.

*...each area's different. Like I know in the Southern Isles they're struggling to implement the role because they can't get staff to do just general nursing [general nursing care as opposed to the more focussed role of FHN] (Family Health Nurse 2004).*

The perception of the role held by the facilitator on the one hand, and some of the nurses on the other, has the potential for conflict.

*A lot of my work, I still do what I was doing prior to the course, a lot of leg ulcers .... You know. Which is where [the facilitator] and I differ, because she keeps saying you've got staff nurses to do that. You don't always have staff nurses. You are working as part of a team and we're covering a huge area. If there are two nurses on, you are doing your bit at the other end (Family Health Nurse 2004).*

The above nurse is, arguably, functioning in a more generalist sense than a FHN who is doing little or no work that may have been the province of the district nurse. The insistence on the part of the facilitator that FHNs should not be dressing leg ulcers appears to confine the FHN role to a specialised niche. The everyday performance of the FHN constructs the role as a more flexible one, within which the nurse draws on a concurrently held district nursing identity to provide what she perceives to be a contextually appropriate performance of professional work. It is in examples such as this contest over the performance of the new professional identity,

that the technologies of the self, introduced and explored in the context of professional work in chapter six are again obvious. The technologies of the self (Foucault 1988), or self-surveillance (McDowell and Court 1994), that are employed in the professional work space, serve to render the professional performance personally coherent. But for the above nurse, the need to construct a coherent and contextually appropriate professional performance, conflicts with the facilitator's notion of coherence, which consists of a more confined nursing role. The following nurse argues that while she may be going in to a patient's home to dress a leg ulcer, the FHN training changes the way that she does that, so expanding the professional task beyond the conventional practice of district nursing:

*I always sort of look beyond the elderly person and I am always asking, is there any family and where are they? Are they on the island or are they away? And I am trying to get more information ... I would say it had definitely changed the way I practise (Family Health Nurse 2004).*

Yet this focus on where the rest of the family are and whether they may be able to be helpful or supportive, positions the nurse as an agent of the state in so far as shifting the focus of healthcare on to the community, rather than as the responsibility of government. The success of this rolling back of the state depends on families actually agreeing to pick up what governments are no longer willing to do and furthermore there is often a marked gendering in just who picks up this community care (Craig 1992; Joseph and Hallman 1998; Lerner 1998).

One of the key issues for Family Health Nurses was having the new role understood by 'others', and amongst these 'others' are other nurses. Because the FHNs mostly work in teams alongside other nurses there is potential for role overlap.

*The district nurses, especially the well established ones that maybe have their foot in the door, think that we're not doing anything they haven't done ... and nobody said anything to us and that's not right (Family Health Nurse 2004).*

The above nurse also reinforces the way that some ‘other’ nurses see the new nursing role as having been imposed rather than arrived at by a process of consultation. When I arrived to speak with one of the Family Health Nurses I witnessed an interaction between the Family Health Nurse and a District Nurse that worked out of the same practice. The District Nurse appeared annoyed at the amount of time given to meetings about the implementation of the Family Health Nurse role and the role overlap that she perceived with her own role. I had a clear sense that the District Nurse felt threatened by the FHN role. I asked the nurse below if she found it difficult to have her role understood by other nurses. While she said that she did not see any issue having the role understood by other nurses, she then went on to say that ‘a lot of people still think that you are the district nurse’.

*No. It's not such an issue really. It's a small team and I think in the rural area ... a lot of people still think you are the district nurse. You know .... We've left leaflets in the surgery explaining about the family health nurse with my name and telephone number, but I've never ever had any calls from anybody to do with the family health thing (Family Health Nurse 2004)*

Constructing the FHN in Scotland *not* as the first point of contact means that nurses must rely on others for referrals, although most nurses have kept some families from their previous district nursing case-load. Referrals may come from other nurses, doctors, or patients may self-refer. In order to refer to the FHN then it is imperative that patients, doctors and other nurses understand the FHN role so as to understand who should be referred. One nurse was concerned that the Family Health Nurse role was not reduced to a role that was fully occupied with ‘problem’ cases. She noted the stigma that had historically been attached to those who were referred to social workers and felt that this would be counterproductive:

*Now if we get to be seen as just going into people with problems, especially with family problems, that would be a backward step I think for family health nurses, whereas my understanding of the role is that we are preventing, we*

*are trying to prevent problems, and the fact that we are there, somebody that can spend time with that, so I am trying to keep you know at that level so that you are seeing a wide range of people who don't necessarily have a problem (Family Health Nurse 2004).*

Facilitating this role understanding has been part of the task of the FHN facilitator. The facilitator had been in post for about nine months by the time of my second visit and it was during the second visit that most of the transcript data used in this chapter were generated. Clearly role understanding remains an issue. It is not only nurses, doctors and communities that need to understand the role, but also Health Board managers, funding bodies, and ultimately the Scottish Executive Health Department needs to be convinced of the value of maintaining this new nursing role.

### **Focussing on families and public health**

Nurses saw the greatest difference between the nursing roles that they had done before and FHN work as revolving around health promotion and preventative work. This focus is completely consistent with government initiatives to improve population health by investing in primary health care. For those nurses who had been able to fully embrace the role, one of the key benefits that they perceived was the permission to spend greater amounts of time with patients, without the need to get through a task-based list such as that which would be necessary in district nursing.

*you are looking at the whole of community health care, you're looking forward instead of backwards, instead of treating the disease we're looking forward to promoting optimum health in the community (Family Health Nurse 2004)*

The philosophical underpinnings of the FHN programme focus on family assessment and part of this assessment is the identification of risk factors for the development of disease. Key assessment tools of FHN practice are the genogram and ecomap. Both tools enable the construction of genetic knowledge about individuals and families and

this knowledge in turn allows for identification and possible control of health risks, particularly those for which no treatment or cure is available (College of Nursing 2001b).

While not every family in a Family Health Nurse's case load will have an in-depth assessment, those that do will complete a genogram with the FHN. It is, of course, common practice to 'take a history' at any consultation regarding health but the genogram, as well as providing information over three generations about disease and risk of disease, provides a comprehensive picture of family members and their relationships across three generations (College of Nursing 2001a). The information on a genogram is limited in some ways as the following nurse points out. She has 'extra' knowledge by virtue of the fact that she lives and works in a very small community; this is not the case with all FHNs:

*but that also then gives you a problem with the fact there are lots of things that you mustn't write down. That you cannot write down. Say, for instance, you do a genogram with a patient, they say well we've got eight in the family. I've got three brothers and four sisters, and you know where there's another two they know nothing about, or perhaps they're not saying anything about. It could be one or the other but you might often have that knowledge and not be able to say anything (Family Health Nurse 2004).*

Thus the genogram is only as good as the information that goes into it and there may be limitations around what can be put on it.

The ecomap is a visual representation of the family in relation to the community. It is primarily designed to show relationships between family members and external systems such as the school, health system, work, and spiritual community. It can also include temporal information such as how much time is spent getting to health care, buying food and other goods for the family. The ecomap shows up family resources in persons and systems. "The ecomap is a paper and pencil simulation developed as a family assessment, planning, and intervention tool"

(College of Nursing 2001c: 1). The following nurse sees the genogram and ecomap as tools with which:

*we're there, to enable people to see where they are in the picture within their family, within their close community, and within the wider community, to try to see the bigger picture and to see how well they could be if they possibly had a few changes, and you start off with doing your genogram, family history, and going back about three generations to see what people died of and to see what illnesses they had, to see what is likely for future generations to have and what needs to be avoided or what could be done better (Family Health Nurse 2004)*

This focus on in-depth assessment and history taking is seen to be essential to 'map' a health profile, which also, of course, becomes a 'risk profile'.

There has been a great deal of critique in both the critical public health literatures and in the 'risk' literatures about the construction of the notion of risk and process of assessing risk and to some extent these have been dealt with in chapter four (Dean 1997, 1999; Lupton 1999a; Nettleton 1997; Petersen and Lupton 1996; Petersen 1997). Within contemporary understandings of the connectedness of notions of risk and rule, what Rose (1997) called the New Prudentialism, an additional role is suggested where the professions become "calculators, managers and 'tutors of risk factors', taking on educative, estimative and preventative functions" (Rose 1997: 219). The educative function is clear in the following transcript:

*Educating the patient, actually, a lot of it would probably be about educating them in one way or another, you were trying to get them to see that they could do something to help themselves, especially if they have a history of different diseases that, there are so many factors involved that there was a lot they could do, they didn't necessarily just have to accept it, just general issues, relating to the family more, you know, instead of just concentrating on the one person, the focus, well the focus is the family, and you can see a lot, but you have to build up the relationship, and it gives you time to do that, because a lot of the work you would do, you would not be able to go in and then one off, you know. They have to get to know you (Family Health Nurse 2004).*

The gaze of the FHN is not a superficial, but rather a penetrative, one with the high intensity nature of the FHN assessment being obvious in the above transcript. Conducting an analysis of a family using a genogram and ecomap is, quite obviously, very time consuming and this is perhaps one of the key differences in the Family Health Nursing role and that is that the role gives the nurse permission to take time with patients and families. The very comprehensive nature of the FHN assessment means that the nurse really comes to know the family very well and a high level of trust is built up with some families who may originally have been resistant:

*I will give you a scenario. Just now I've got a lady with Alzheimers, pretty bad Alzheimers, in her 80s, husband is 90 and he's been the main carer. They've been refusing help up until now. This lady wanders the roads in [the village]. She goes out and she injured her leg a couple of weeks ago. He told me she climbed out the windows because he has to lock the doors. So there has been pressure on from the family to accept more help, community alarm. So I was trying to put my PDSA (plan, do, study, act) thing on family health here so I organised a community alarm, got somebody in to do personal care on this lady when she will accept it – she is still very strong minded. And really trying to give him the help and support that he needs and trying to tell him, you know, you've got to take, organise a week's respite for October and somebody from Alzheimers has actually been out. So it has taken a long time to get there with that couple (Family Health Nurse 2004).*

This high level of input and surveillance of patients raises questions of paternalism, which is probably inherent in most types of health care work anyway, but has the potential to be much more marked due to the nature of FHN work. There are of course several ways to read what could be argued to be a highly intrusive process that FHNs go through when they conduct genograms and ecomaps and herein lies the paradox at the heart of health care, so clearly articulated by Lupton, who says that “western societies in the early twenty-first century are characterized by people’s increasing disillusionment with scientific medicine” while at the same time “there is also an increasing dependence upon biomedicine to provide the answers to social as well as medical problems” (2003: 1). Lupton goes on to point out that:

With the current obsession for locating the genetic precursor of illnesses, diseases and behaviours, the knowledge base of scientific medicine has encroached even further into defining the limits of normality and the proper functioning and deportment of the human body. Yet it cannot be denied that illness and disease are debilitating states, and that the populations of western societies are vastly longer lived and more free of pain and discomfort now than at any other time (2003: 1).

Nursing work is located in this paradoxical space in a potentially very powerful way (see Perron et al. 2005), but this potentially very powerful position is somewhat subverted by the nurse's subordinated position within the health care arena more generally:

The ideology that positions nurses as empathetic, as striving to 'know the patient' as an individual, as a 'whole person' rather than as just a set of symptoms, can be interpreted as an explicit exposition of surveillance and disciplining of patient's bodies. For nurses, the clinical gaze is extended from the external features of the patient's body to the private thoughts, feelings and everyday lives of patients, in the quest to find the patient's 'real' or 'authentic' character in a way which may be considered even more intrusive (Lupton 2003: 132-133).

Lupton's 'clinical gaze' really seems to suggest a medical gaze, whereas it may be analytically more useful to suggest the presence of a nursing gaze. The very extension of what Lupton calls the 'clinical gaze' opens a space to speak of a nursing gaze which in the desire to address the individual as a 'whole person' fits very neatly with the concept of holism in nursing. This gaze is a complex one that is simultaneously controlling and makes attempts at empowerment, and is hard to articulate. Dean speaks of empowerment as a 'technology of citizenship' which "engage[s] us as active and free citizens ... as agents capable of taking control of our own risks" (1997: 220).

Patients (subjects) can also contest and resist being the objects of this type of gaze and a number of nurses indicated that they had patients or families referred to them who did not wish to be assessed by the FHN. Patients cannot simply be

constructed as passive, docile bodies that are made infinitely malleable by authoritative nurses, because they also resist, contest, and redeploy information, education and intervention by health care professionals. Besides from the critical analysis of health promotion work above, which is never simply mapped on to populations; governing bodies demand accountability from health professionals in order to justify funding and support.

Becoming auditable subjects: Proving value

The very nature of the type of health promotion work that Family Health Nurses are doing means that the outcomes will not be known for many years and so judging the efficacy of the role in the present is difficult:

*It's not something that can be evaluated over a year or so. It's going to take years and years to see if it's going to make a difference (Family Health Nurse 2004).*

The twist of giving nurses permission to take time with patients and families to do lengthy assessments is that in the absence of a conventional task based list, where the nurse appears to be getting through a lot of cases, there is the ever present need for processes of audit. I have already indicated that permission to take time is one of the hallmarks of the FHN role and the time taken to do various parts of the role with full FHN assessments taking approximately three hours, it is perhaps this time factor that is one of the more difficult areas to quantify. As I have already indicated in this thesis, much nursing work is hard to measure, but in order to maintain a position within health care FHN work needs to be quantified in some way. Little if any health care work escapes some type of auditing process. I asked the following nurse if she thought that her professional work 'made a difference'. She answered that she thought it had, but talked about the difficulty in quantifying that difference:

*I think I have, I feel I have. By how I could measure it I don't know. Our documentation does, to a certain extent, lend itself to whether you'd gone in as a supportive role or whether you do an action plan to help somebody, whether it be to lose weight or stop smoking or whatever. A lifestyle kind of change, you know, so you can within your action plan document whether you are doing lifestyle changes or whether it's a supportive kind of role....That's the only way you can document it really (Family Health Nurse 2004).*

Reading between the lines when speaking with the FHN facilitator, I suspect that there was some very concrete pressure being brought to bear to provide evidence of the value of FHN work and there was a very significant requirement for documentation commensurate with the wider move within the public sector for more accountability. This documentation went well beyond the need to list the tasks that were carried out, which the facilitator saw as an inadequate representation of what the nurses did. But nurses struggled to work out just what kind of documentation it was that was going to meet the facilitator's requirements, and they were concerned about the time that this extensive documentation would take:

*She wants us to keep a diary of our day's events, week's events, everything we did from every meeting so she could see what we were doing with our time. She wanted us to, sort of, do a couple of scenarios where we could implement these PDSA cycles. I have also written a brief report for the two shows and there are other things she mentioned about competencies within the framework, how we can relate them to our work. But, having spoken to [two other FHNs] after you left on Wednesday, we all agreed that nobody had enough time to do what was being asked (Family Health Nurse 2004).*

Dean (1997: 220) coined the term 'technologies of performance' to describe the ways that the know-how of professionals comes to be subsumed to "new formal calculative regimes". The goal of these technologies is to transform professionals into calculating individuals, the trust in whom can be restored because their practice is accountable and transparent, and of key importance in this transformation are processes of audit (Dean 1997: 221). Audit is not an innocent process but one whereby:

Government by audit transforms that which is to be governed: rendering something auditable shapes the processes that are to be audited, and the logics and technical requirements of audit displace the internal logics of expertise.

Thus the emphasis on defined and measurable goals and targets in the work that professionals do with their abjected clients is an element within a much wider re-configuration of methods for the government of specialist activities (Rose 1996: 351).

Rose goes on to say that the formal independence of the professional is retained “while utilizing new techniques of accountability to render their decisions visible, calculable and amenable to evaluation” (ibid). The following provides a clear example of Rose’s formulation at work. One nurse had attempted to insert her position in the practice team by utilising the Read Codes (clinical terms). Read Codes were developed for the use of all health care professionals and are “a comprehensive list of terms to describe the care and treatment of patients, they enable computer systems to firstly capture and then retrieve on demand patient information in natural clinical language” (NHS Information Authority 2004a). The Read Codes represent an attempt at a standardised electronic clinical vocabulary and are “stored as data which can be retrieved and analysed to provide information across a number of disciplines such as audit and statistics in addition to the clinical application” (ibid). Clinical Terms are widely used in medical practices that are computerised, with usage predicted to rise to ninety percent over the next three years (ibid). From 2004, migration from Read Codes to a new system called SNOMED CT has been occurring. SNOMED CT is said to be at the “cutting edge of clinical vocabularies” while the older versions of the Read Codes “no longer meet the demands placed on clinical terminologies by modern medicine supported by integrated electronic environment” (ibid).

The adoption of this ‘language’ is interesting on a number of levels and raises questions about the degree to which nursing can be captured within these ‘clinical vocabularies’. As the nurse who was working with the Read Codes noted, there was no provision for indicating the time that particular nursing activities, particularly Family Health Nursing, took. While language such as the Read Codes or SNOMED

CT can be endlessly updated, Rose's caution is worth remembering that the process of audit is not an innocent one and it ultimately shapes practice. While it may not be possible, or desirable to subvert the audit culture and government by audit altogether, it would certainly be wise to critically assess the entwined nature of practice and audit, when practice is captured via a process of reductionism within the language of audit of whatever form.

### **Concluding Comments**

Introducing a new nursing role into an already established bundle of specialist community nursing roles has been and continues to be a challenging undertaking. The desire on the part of the World Health Organisation's European office to promote a generalist nursing role as the first point of contact with the health care system has not eventuated in the Scottish context, except in those places where nurses were already the first or only point of health care contact. Extensive use has been made of European Union funding to decrease isolation by building bridges for populations living on small islands off the coast of the main Western Isles. Thus, over time there are fewer situations in which there will be a call for sole practitioner nurses on isolated islands that have small populations unable to support a general practice.

There appears to be a confusion of goals that has happened in the taking up of the FHN role as part of the answer to the need for health professionals in rural and remote places. The way that nurses have been reinserted into practice teams means they are unable to be a first point of contact. The way that the FHN has developed in Scotland is really a role designed to help assess and manage families with very complex health needs. When FHNs are inserted into practice teams, as they have been in the Western Isles, their roles are modified depending upon the skill-mix context in

which they work. This flexibility is both a strength and a weakness. Its strength lies in the way that it can adapt to meet health ‘needs’<sup>40</sup>, but this very fluidity makes the role hard to define and thus explain (and audit).

While FHNs are not in conflict with doctors, to be functional members of the team working out of a practice, roles of team members need to be understood so that the best use can be made of the different skills that different members bring. Teams need to know enough about each other’s roles so that referrals can be made between members. And if each of the roles encompassed within a team are not well understood then there is potential for conflict and fragmentation of care. New Zealand remote nurses do not come into conflict with ‘other’ nursing roles in the everyday practice of their work due to the isolated nature of it. In this sense remoteness allows space for the performance of generalist professional identities, that working in close proximity with others may not.

While the pilot for the Family Health Nurse role has been developed in remote and rural areas there is significant interest in the potential of this role in both urban and inner cities in Scotland and elsewhere in the UK (*Nursing for Health* 2001: 30). Indeed, in 2004, a pilot was initiated in Glasgow. As another attempt to insert nurses as the first point of contact, in the Glasgow pilot, nurses will work “alongside Family Doctors as originally envisaged by WHO Europe in Health21” (Family Health Nursing in Scotland: A report on the WHO pilot 2003: 25). Just how these nurses’ practice comes to be performed will be very interesting to observe.

The FHNs that I spoke to in the Western Isles clearly saw themselves as generalists, but sometimes modified this to ‘specialist generalist’ and particularly those in smaller areas of the Islands. Although it is not generally appropriate to

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<sup>40</sup> ‘Needs’ are not objectively quantifiable entities, but rather shifting and contested understandings.

introduce new material in a conclusion, I have chosen to include this quotation as it helps to make my point:

*Nursing is a generalist, it should be a generalist role. Especially out in community. It is very much a generalist, a specialist generalist role really. That you can, you know, you cover a lot of things. And the idea is that you are, you are very competent in a whole pile of these, but the things you can't cope with you can refer to the specialist nurses. And there is no need for doctors to be involved. When you think about it, a doctor diagnoses and prescribes. Other than that you can forget doctors. For all they are important ... But nurses have, traditionally, always soaked up whatever jobs nobody else was willing to do, and there is still a bit of that there. And it isn't good enough and I feel that nurses should take hold of their own roles and say no, this is a separate role. We are not doctors; we don't need a medical model. We are nurses. And there is nothing wrong with being a nurse. And, I think, I feel very strongly the fact that this is the case, where nurses should be encouraged to stand up and speak for themselves .... And to recognise that we don't want to be doctors. We are nurses. We want to nurse. All I ever wanted to do all my life was nursing and I just love nursing (Family Health Nurse 2004).*

The above nurse claims a space for nursing as distinct and needing articulation in order that the misunderstanding of changed and upskilled nursing roles encroaching on medicine is put in its place. The dominance of the medical model is such that it seems difficult to think outside of it.

The commitment that FHN training gives to public health and preventative matters is not one that biomedicine has given itself time to act on in other than a limited way, given the very short nature of most medical consultations. Focussing on prevention and promotion positions nurses very strategically within government health strategies that are committed to improved population health. The high intensity nature of FHN assessments, on the face of it, places nurses in a very powerful position and could make families feel very vulnerable and in order for the process to work high degrees of trust must be gained. Paying attention to the practice of nurses indicates another element at work here that is not normally acknowledged in simple analyses of power in the medical and nursing encounter.

In chapter five I talked about the mutual surveillance aspect of living in a rural community as a health professional. Within remote and rural places where the nurse is a very obvious member of the community (in ways that are not even the case in small towns), there is the potential for a very full performance of a health promotion and protection role. If this mutual surveillance does in fact work to modify health behaviours, then the rural should be a site in which great gains in health status could potentially be made. But the effectiveness of this surveillance is an open question, that would require further research, especially when I think of the example of the nurse who smokes - but never in public! The motivations for lifestyle change in order to protect health are very complex and perhaps all that mutual surveillance does is heighten awareness. The measurement of how much difference it makes, or might make would be very problematic.

The FHN role being piloted in Glasgow currently will probably provide the most telling picture of what the potential is for generalist nurses to work in urban environments<sup>41</sup>. But it seems that as soon as the nursing role is taken out of the solo context and has to work in with other roles, the need to articulate exactly what the contribution each makes becomes more acute. When nurses work in a solo capacity they do what health care work is there to do and that they are competent within their professional qualification to do. Articulating this breadth in the context of specialisation in nursing roles becomes problematic. Articulating exactly what it is that the nursing contribution is and means remains a contested terrain in the conventional rural primary care nursing role and within roles such as the FHN. I think this is what the nurse above meant when she said that nurses need to ‘speak for

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<sup>41</sup> There are some very recent moves in New Zealand for nurses to work in underserved areas in cities such as the suburb of Aranui in Christchurch.

themselves', but in order to do that they need a language. It is the issue of just how this language might be constructed that is the task of the following chapter.

## **Speaking into the gap: everyday practices, knowledge, power and language**

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### **Introduction**

One of the tasks of this thesis has been to explore the extent to which nurses not only are already, but can in the future, meet the need for rural primary health care services, and further to ask if this model of primary health care delivery has the potential to contribute beyond the rural. Rural nursing represents a model of care, which has the potential to decrease fragmentation of care delivery, and to ensure follow-up as much as this can ever be guaranteed, due to nurses' positioning within the community in highly visible and approachable ways.

As has been shown in all of the previous chapters, nurses currently make a significant and well-managed contribution to rural primary health care. By well-managed, I mean the ways that nurses successfully negotiate governed and governable professional selves. Nurses' governed selves are obvious in the ways that they manage medico-legal risk, interprofessional boundaries, and the maintenance of their professional identities utilising technologies of the self to construct notions of appropriate clinical and personal conduct. Quite simply put, the very on-going presence of remote, solo, rural nurses in parts of New Zealand shows that a generalist nursing role can 'work' as a means of providing primary health care. Analytically

speaking, 'other' health care practitioners need to be removed from immediate contact in order to 'see' what nurses can do by themselves<sup>42</sup>.

In some sense models of rural nursing could be argued to lead rather than follow in current understandings of primary health care delivery with a preventative focus. But as was demonstrated in the previous chapter, inserting a new nursing role into an already established network of nursing roles can be problematic and this is at least in part because of the lack of a language to talk about what specific parts of nursing do (Lawler 1991) and contribute to primary health care. The need for an authoritative speaking position is not confined to rural nursing, but nursing in general struggles with the lack of language (see also Buresh and Gordon 2000).

The issue of language, its definition, ownership and reception forms the core problematic in this chapter. As has been demonstrated in the previous chapters, the available languages of biomedicine, holism or mainstream nursing alone are inadequate to represent the everyday practice of rural nursing. Putting into speech what rural generalist nursing is and does becomes crucial when a language for talking about this work is needed by means of explanation to managers and policy makers and the public. But there is also a deeper set of questions that arise from the issues surrounding language that chip away at the core nature of language, its development and deployment. These questions must be addressed in the effort to think into the complex and contested terrain of professional work in health care, and also in order to move the debate firmly away from simple structural understandings and analyses of power, profession and place. While analyses at the level of structure provide important awarenesses, they also tend to construct something of an 'iron cage', where nothing short of a revolution will unsettle the existing power relations. In most cases

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<sup>42</sup> I am not advocating a nursing role where nurses work alone, in fact I do not believe it is desirable, but the removal of other health care practitioners allows a particular type of reading of what it is that nurses can do.

in the social world, change is a much more subtle matter, and efforts at promoting change often need to go much deeper and wider than structural analyses allow.

The chapter is divided into four parts. The first section discusses the connections between embodied practice, language, knowledge, power and control. Biomedical dominance over the communicative terms of the health care encounter serves to subjugate and make difficult the development of any language of nursing. Using understandings from both poststructuralist and psychoanalytic theory, a 'gap' is envisaged into which there is the potential for the feminised profession of nursing to speak. The second section, drawing on the potential gap articulated in the first section, discusses the concept of unveiling the phallus, since the phallus can only play its dominant role when veiled, when seeming to be neutral. The section deconstructs some of the ways that medical knowledges are produced so challenging their presentation as the pure application of already-known scientific knowledge. The difficulty in putting nursing knowledge into language is also discussed in the context of nurses' positioning as those who are seen to have a monopoly on the concept of care and as socially mandated agents of abjection. Both of these positionings are seen to be potentially 'unspeakable', and (in)credible. The third section explores the question of the relative credibility of languages and the way that different languages are received differently at different times, even if they need to be 'translated' in order to gain credibility, thus 'gaps' are identified that provide space for nursing to take up a more visible place in health care, while also acknowledging the barriers that exist to the success of this endeavour. The fourth and final section looks at the issue of inserting the language of nursing into technologies of government and explores the potential inherent in nurses as proximal practitioners to address the goals of the Primary Health Care Strategy, while remaining ambivalent about whether there is any

success in inserting the language of care into technologies of government. Rather, nurses appear to need to utilise some form of ‘pidgin’ in order to make their contribution heard in the health care arena. I conclude with ambivalent optimism, if such a thing is possible, for the insertion of a ‘new’ language of nursing that is credible and convincing to those who oil the wheels of rural health policy in particular and primary health care policy in general.

### **The challenge of embodied practice and the problem of language**

I have talked about the problematic nature and contested status of nursing knowledge, but have argued that the very existence of the model of rural health care delivery embodied in the everyday practices of rural and remote nurses represents a challenge to conventional systems of primary health care delivery that rely heavily on biomedicine. In terms of the power relations that operate for nurses, I have highlighted the ways that New Zealand rural nurses have struggled to insert their particular contribution to rural health care as one of ‘maxi-nursing’ rather than one of ‘mini-doctoring’ with the nurses being adamant that the core of their practice is, and remains, nursing. This fundamental misunderstanding requires a way of explaining the nursing contribution in the face of biomedical dominance.

As a way into thinking about the possibility that things might be otherwise, thus addressing the challenge that several nurses issued about the utility of a critical approach, and focussing on language, I want to offer three vignettes. These vignettes are indicative of the tense space into which nurses must attempt to speak. The authoritative language of biomedicine is evident in the first vignette. Although the first vignette is an historical example, the continued need for the accommodation to biomedicine is also evident in the extracts from the nurses presented in the second

vignette. Contemporary rural nurses deploy the language of biomedicine in order to have credibility when speaking with doctors. In the final vignette, a rural nursing researcher calls for the need to develop a language of nursing in general in order to mark out the space of nursing practice.

I repeat the first vignette from the preface to the thesis. As a seventeen year old, straight out of school in the mid 1970s, one of the doctors that lectured me during my nursing training said that one of the most important things that a nurse can do is learn the terminology used by doctors. Doctors clearly controlled the communicative terms of the health care encounter. The second vignette is drawn from the data generated during interviews with rural and remote nurses. In the context of speaking about the value of postgraduate papers carried out via the National Centre for Rural Health the following two nurses said of the advanced (physical) assessment course:

*Now I know what I'm identifying, I know how to identify it. It also helps you with that language for them, talking to a doctor, that anatomical language...you can actually identify the anatomical landmarks, you can give them to the doctor. Especially if you are talking to a doctor that doesn't know you, it just makes them sort of perk up their ears and listen, because you are talking their language (Rural registered nurse. 2002).*

*I did a certificate which involved health assessment which was really hands-on and it went through doing really good physical assessments and also giving us a language to use and for me that was really, absolutely important ... a lot of the stuff I've learnt, I learnt on my own so I've learnt by visualising systems in my head and when I assess people I go what's this symptom, what system's it relating to, what are the possible sorts of things? So I'm really skilled at assessing people, but I am not so skilled at writing down what I assess, so I can usually come to a diagnosis that's accurate. So I go from assessment to diagnosis. But the middle bit of writing down what I am actually doing and using the appropriate language is something that I'm not that good at.... I don't have that language. I never was particularly interested in having it either. So I think the course has encouraged us to be a lot more professional (Rural registered nurse. 2003).*

The third; in 2001 at the first conference of rural nurses to be held in New Zealand, Professor Keyzer, who held the chair of nursing (rural and remote) at the University

of Sydney issued a challenge. The challenge was, he said, “to create a nursing language that unifies nursing, describes the nursing world and directs nursing developments” (2001: 1). Language, Keyzer argued, is an important vehicle for communicating the nature of nursing and nursing work and “the uncritical adoption of the language used by the medical profession, economic rationalists and general managers contributes to our dependence on the prior formulations of others determining the role and status of professional nurses” (2001: 1).

Given the supposed shifting nature of power relations in health care, how am I to understand that it appears to remain necessary, or at least strategic, for nurses to learn and use the language of biomedicine, and that one of the above nurses construes learning the biomedical language as ‘being more professional’, and by implication being more professional in this way is seen as positive (see also Bondi 2004: 323)? Why at this moment in time is there space to say that rural nursing needs to develop its own language, as Keyzer (2001) does, bearing in mind that things only become thinkable under certain circumstances? In my reading, the process that Keyzer wants to attempt to subvert by suggesting that nursing needs to develop its own language, is that of colonisation by medicine. This is especially pertinent to rural nursing since it is in these boundary sites that there is more fluidity of role boundaries (even if through a semi-permeable membrane!).

Rural primary care nurses inhabit a middle space in which they engage in everyday practices and deploy bodies of knowledge from both nursing and biomedicine. This hybrid practice is often poorly understood and this is evident in comments made by other nurses and also doctors who say things to rural nurses like ‘why don’t you just go and train to be a doctor?’ Ontologically speaking, this is not a way of being that most nurses want, but neither do current definitions of their work

provide an adequate epistemological framework within which to articulate professional identities. Rural primary care nurses are some of those border/boundary dwellers who drag our thinking beyond the binary biomedicine/nursing. This attempt to go beyond the binary could prove to be a very productive re-thinking of health work, power relations and everyday practices.

At first glance the roles of the Feldscher in Europe, and the physician assistant in the United States could be argued to span the binary. The Feldscher, a person with training in medicine and surgery, but without formal medical qualifications, functions as a physician's or surgeon's assistant in underserved areas in parts of Europe. In the United States during the mid 1960s as a response to a shortage of doctors in primary care, the role of physician assistant was introduced to assist in increasing access to health care for people in underserved areas (Mittman 2002). The key difference is the training that physician assistants and Feldschers receive. The training relies unequivocally on the biomedical framework. The nurses who take on extended or expanded roles have their education base located in nursing, and this produces a professional identity that is significantly different from that of the physician assistant. In the United States physician assistants must be associated with a physician, whereas while nurse practitioners in the United States do very similar work, there is no requirement that they be attached to a physician and in most cases, the state board of nursing is the regulatory body for nurse practitioners (Mittman 2002: 487).

Rural primary care nurses' everyday practices embody an unspoken alternative language, beyond biomedicine and nursing, which challenges conventional confined health care knowledges and languages. This bringing together of space and knowledge is important because as Davies et al. say:

The universal truth claims of knowledge are fractured through drawing attention to the situated nature of expertise. The places through which

knowledge circulates are, of course, multiple, as knowledges are produced, practiced, contested, consumed, embodied, and stored in the different domains that constitute its geography and transform its meaning (2004: 293).

If language is understood to be performative (Butler 1997b) insofar as it constructs what it purports to name, the process of developing a language of rural nursing simultaneously constructs the rural nursing identity at the same time as it is expressed in language. Thus, the desire to articulate a new language, runs concurrently with the shifting identity of nurses in general and the growing awareness and ownership of an identity as 'rural nurse' which is distinct from any other articulation of nursing practice. Research and courses based out of the National Centre for Rural Health have been instrumental in the task of attempting to define what is particular to rural nursing (Ross 1996; Ross et al. 2000). Courses that the nurses have carried out have helped them to identify the parameters of their own practice with some degree of success. But a great deal more 'language development' is required before rural nursing in particular and nursing in general can clearly articulate practice, and the contribution that this practice makes to primary health care, as is evident in the persistent lack of understanding of the comprehensive model of health care that rural primary care nurses provide. These nurses have yet to construct an authorised speaking position and 'new' *authorised* languages are not simply produced, requiring very particular sets of conditions to facilitate their emergence.

Gesler (1999), who was concerned with language(s) used in health care, suggests two strategies that may be used to resist dominant discourses; deconstruction and intertextuality. Deconstruction, seen as a process of examining texts and discourses and unpacking the ways that claims to truth are made and then contesting these truth claims (ibid), has been part of the task of this thesis and continues in this chapter. By intertextuality Gesler (1999: 20) refers to "the strategy of reading several

discourses against each other, interpreting texts in the light of other texts” which he says allows for a questioning of received wisdom and an opening of the discussion to alternative voices. But it is important to be a little cautious about the potential of intertextuality and its potential as a change agent. Following Haraway (1991), Gesler says that this “working with the ‘play of difference’ [as occurs in intertextuality] enables us to oppose relationships based solely on dominance hierarchies or oppositions and replace them with relationships of equality and cooperation” (ibid). Although it is crucially important to facilitate the voicing of alternative discourses, the existing power relations within the health care encounter make for a much more measured and slow process than the apparently simple replacement of hierarchical relationships with those of equality and cooperation.

#### Contest over language: knowledge, power, and control

Language gives us access to the discourses, the disciplinary regimes, in which everyday practice is embedded. We usually only become aware of the shape and existence of a discourse once it is fairly well formed with recognisable features that provide some internal coherence; in short we come to understand a new language, or perhaps a new dialect. The desire to construct a language with which rural primary care nursing can be articulated inevitably raises questions about the connections between language, knowledge, power and control due to the uneven power relations operating in health care work. In order to better understand the way that language may be deployed in a feminised profession and how people come to occupy ‘authorised’ speaking positions, it is important to tease out the relationship between language, knowledge, discourse, power and everyday practices.

An emphasis on language is central in both poststructuralist and psychoanalytic theorising. Within poststructuralist approaches words do not reflect pre-existing meaning, but it is words, organised into languages, discourses and disciplines that are our social currency. It is with words that we attempt to describe and explain our everyday practices and to articulate our knowledge. But even more fundamentally, in psychoanalytic approaches, particularly as interpreted by Lacan, language is the “key to psychical development and sexual identity” (Bondi 1997: 251). In terms of investigating gendered difference in health/medical languages, the fundamental function of language in structuring sexual identity proposed within psychoanalytic theories provides a promising avenue of investigation.

Struggles over language have long been important in feminist theorising (see Lakoff 1975; Spender 1980) ranging from the recognition of language as ‘man-made’, to the push for the elimination of sexist language (Hintikka and Hintikka 1983; Vetterling-Braggin 1981), and the reclaiming of words previously deemed derogatory such as dyke and queer (Daly and Caputi 1987). But there have been strong critiques of the potential for transformation offered by both the use of non-sexist language and the reversal involved in a gynocentric focus (Bondi 1997; Grosz 1989). Indeed, Bondi argues that both approaches “underestimate the significance of gender asymmetry in language and gender identities”, seeming to conceive of gender inequalities as superficial (1997: 248), and thus easily ‘rectified’.

While paying attention to language at a superficial level by lobbying for the use of non-sexist language has been important, it has assumed a separation between language, knowledge and embodiment, thus potentially burying, but not erasing the gendered character of language and knowledge (Bondi 1997). A deeper and perhaps more complex level of analysis of language, knowledge, power, and gender together

can be profitably undertaken to attempt to provide greater explanatory power in thinking about contests around gendered health care languages. More contemporary critiques have made connections between language, knowledge, power and gender and highlighted language as the site of simultaneous construction and contestation over meaning and legitimacy. Rose (2003: 46), in discussing the work of Grosz and Irigaray and their interpretations of the “relationship between language and what lies beyond its limits”, begins with the assumption that “language and knowledge are so inextricably bound together as to be the same thing”. The connections that poststructuralist thought has made between power and knowledge prompt an analysis of all three simultaneously; language/knowledge/power and within this analysis, gender comes to be seen as a core organising category.

Making knowledges/languages

Bio-medical dominance

Language is not automatically available to represent what it is that nurses do, Lawler (1991), for example, highlights the ways that the ‘body work’ nurses do, or what Lawler terms ‘somological practice’, has had no formal language to describe it and has thus remained relatively invisible. Furthermore even when language is available, such concepts as ‘care’ are extremely difficult to both reduce to language, and once represented in language often become subordinated to the language of biomedicine. So although nurses are authorised to deploy expert knowledges in Foucauldian terms to govern population health, it seems that all expert knowledges are not created equal. A hierarchy of different forms of expertise appears to operate in the subordination of nursing knowledge. In chapter three I discussed the ways that medicine historically came to occupy a dominant position within the terrain of health care. One of the

means of achieving this position was the construction of and control over a 'scientific' vocabulary.

The dominant positioning of biomedicine and the authoritative knowledge claims that it makes in the name of science have proven to be fairly hard to challenge. Science appears difficult to challenge because of its "apparently secure grounding in reason, logic, empirical evidence, and dispassionate debate" (Gieryn 1999: 25). The authority claims of science are justified by the "unique, necessary, and universal elements of its practice – behaviours, dispositions, methods, rules, tools, and languages that simply work best to make truth" (ibid). Those who argue that knowledge claims in science are but "momentary discursive accomplishments are perceived as threats to the firmament of civilisation" (ibid). The boundaries and knowledge claims of biomedicine are strongly defended, and the inadmissibility of alternative practices, explanations, and knowledges is evident in the struggles that groups such as chiropractors have in becoming recognised as anything other than quacks.

Some of the early claims to healing made in the name of medical science were made with little foundation. Furthermore, some advances in population health that had been attributed to medical science were in fact as a result of social models (McKeown 1979). But to some extent the rhetoric of biomedicine and the reality appeared to converge at least to some degree, with language being seen, in modernist terms, to reflect 'reality' or 'truth', and biomedicine indeed being able to claim credit for such advances as anaesthesia. Part of the process of maintaining this professional dominance lay in constructing and owning a language which made intelligible a body of esoteric knowledge to those who were admitted to the ranks of biomedicine. In the face of the authorised speaking position constructed by biomedicine, the task of

finding an alternative and authorised position from which to speak is not a simple process for nurses.

Traditionally, ‘others’ (such as nurses) need to have at least some understanding of the language of biomedicine in order to ‘help’ doctors, since it is difficult, at least in the West, to practice medicine in isolation from infrastructure and other personnel (I can think of no instances where doctors in New Zealand work without nurses, but nurses can and do work without doctors). Nurses could only have a certain type of access to the language and knowledge base of medicine or they would be a threat to doctors, since they could claim the same knowledge (Gamarnikow 1978). Rather, dominance was maintained by relying on a form of “constrained communication” to extort submission (Bourdieu and Wacquant 2001: 2). The way that biomedicine has controlled the communicative terms under which health care is practised was achieved at least in part by doctors’ participation in the education of nurses which in turn flavoured nurses’ professional development.

When nursing education moved out of hospitals and into polytechnics, the link with doctors became more remote and may have simply provided space for the reflection on and development of a stronger nursing identity (Papps 1997). Papps describes this shift as one that involves “a shift in emphasis from nursing as the acquisition of skills to a more broadly based view of nursing as an activity which requires critical thinking activities applicable to a range of health care settings, and an emphasis on professional practice” (1997: 8). The emancipatory tone of this shift in thinking about nursing is obvious, but Gilbert argues that it actually “involves the exchange of one form of subjectivity for another, as both are equally the effects of power” (2001: 202). The articulation in language of this latter more autonomous identity is no simple matter especially as an adequate articulation in many senses

needs to be able to speak the unspeakable. It is here that I turn to psychoanalytic theory in order to think into the gendered nature of knowledge, language, power and identity and to ask if there is a 'gap' into which nurses can speak.

#### Masculinity, science and the symbolic order

'Owning' language in the way that biomedicine has succeeded in doing is in psychoanalytic terms unsurprising. Psychoanalytic theory offers a way of thinking about how we come to take up gendered speaking positions and subjectivities in the social or symbolic order, since entry into the symbolic order is simultaneously entry into language. This entry is essential because, as Grosz (1989: 39) states: "language is not merely a system of naming, labelling or even communication. It is the threshold of all possible meaning and value".

But, importantly, the symbolic order is not a neutral space into which people in general achieve entry, but rather, it is structured around the primacy of the phallus<sup>43</sup> and the phallogentrism of language. This phallogentric symbolic order privileges masculinity by its association with the phallus. In order for knowledge systems to be seen as powerful, effective and authoritative the differential gendered rules of this order are drawn on (although not in any acknowledged way) to construct credible knowledges. By association in a dualistic schema that sees masculinity and femininity as oppositional, phallogentric knowledges are, above all, rational. It is rationality<sup>44</sup> that is mobilised in the construction of scientific knowledges, of which biomedicine claims to be a part (see Fox-Keller 1984, 1992; Haraway 1988 and Harding 1986, 1991, among many others, for analyses of gender and science). The dominant and

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<sup>43</sup> The notion of the phallus is not intended to map on to a material organ but to be symbolic.

<sup>44</sup> While in some sense rationality can be argued to be 'masculine' which leaves the position of the irrational to be occupied by the feminine, writers such as Irigaray argue not that the feminine is irrational, but that "rationality has been instructed in such a way that the feminine is inevitably repressed" (Homer 2005: 117)

masculine positioning of medical knowledge/language, thus, maps on to the theory of the formation of gendered subjects advanced by Freud and Lacan.

In psychoanalytic terms women (or the feminine) only find a place in the symbolic (language) order within phallogentric language. Thus “women and men occupy different positions in, and in relation to, language” (Bondi 1997: 252). Entering the symbolic order as feminine or masculine is also an entry into a system of value (Grosz 1989), in which the masculine is traditionally valued over the feminine. The understanding of the inherent phallogentrism of language helps to explain why superficial attempts to change language are unlikely to initiate radical change (Bondi 1997). This awareness should also signal a warning against any simplistic attempt to construct a language of nursing without acknowledging the deeply embedded phallogentrism of biomedical language/knowledge systems.

If entry into the symbolic is essential for functioning in the world, then the feminine appears to encounter an intractable problem in terms of representation. If the only avenue open to the feminine is via the phallogentric order then there appears to be little space for alternative readings of femininity. Some feminists, such as Irigaray (1985), for example, have attempted to provide alternative readings. Irigaray’s project is interesting in her attempt to articulate the feminine in positive terms rather than as ‘lack’ or ‘castrated’ as it is conceptualised in Freudian psychoanalysis. But thinking along with Irigaray to address the issue of the positioning of nursing in relation to medicine and the construction of a new imaginary simply requires more imagination than I have, tantalising though the project may be. Furthermore, I am interested in the articulation of this nursing identity in such a way as to render it understandable to policy makers, planners and nurses themselves. Irigaray’s project speaks the feminine as radically ‘other’ to the masculine and such

oppositional constructions do not find ready ears in traditional sites, as a rule (Knights and Kerfoot 2004). It is this need to speak in a language that can be understood that afflicts both feminists (see Bondi 1997) and nurses!

Bondi (1997) turns to Lacanian reworkings of psychoanalysis to think beyond the conceptualisation of the feminine alone as lacking in the symbolic order. Lacan's work provides a productive space because in his formulation of the entry into language both men's and "women's claims to authoritative speaking positions" are undercut (ibid: 253-254). This undercutting follows from Lacan's reconceptualisation of the notion of castration. For Lacan castration or lack, symbolically the preserve of the feminine in Freudian psychoanalytic theory, is reconceived as fundamental to the constitution of both genders and is linguistic as well as sexual (Gallop 1985: 20). Furthermore, the entry of all children into the symbolic is alienating, not only for the feminine, insofar as the child comes to see itself as separate from the mother or carer (Bondi 1997: 251). Most importantly then, we all lack "any masterful understanding of language, and can only signify ourselves in a symbolic system that we do not command, that, rather, commands us" (ibid).

The gap that is opened by understanding both the masculine and the feminine as achieved and not given statuses, and both as symbolically castrated in relation to language, presents a space of possibility for thinking differently about the apparently fixed position of the feminine as permanently and automatically subordinate 'other' in terms of authority in language, which is a potentially productive avenue. But it is important not to overplay this space of possibility since it is a very modest gap that does not automatically address the differential value placed on masculinity and femininity.

Bondi (1997: 253) notes that Lacan associates rational, conscious speaking positions with masculinity, and “the unconscious as site of excess and repression, as radically other, is associated by Lacan with femininity”. Understanding the positioning of the feminine within language as ‘other’ has some explanatory power in understanding problems of speaking a new language of nursing which is constructed as feminine, and therefore unspeakable in its own terms. Of course suggesting that the feminine is unspeakable (asides from projects like Irigaray’s) is something of a stuck point. If we are to accept that the position of the feminine within the symbolic is fixed as negativity then we are condemned to repetition, without hope of change.

### **Working the gap: Unveiling the phallus**

Only modest and oblique interventions are possible in subverting the phallogocentric symbolic order and acknowledging this modesty is important because of the plays of power that locate the masculine, rational and scientific as the norm by which other health care knowledges/languages are judged. The potential for radical shifts in gendered subjectivities offered by poststructuralist theories of the social construction of subjectivity, while seeming to offer great promise in regard to ‘changing the subject’ (Henriques et al. 1984), are a much more limited enterprise. Indeed Callard (2003) argues that the resistance of the subject to change has been vastly underestimated.

Bondi’s (1997: 253) advice in regard to ‘making a difference’ is to work within the phallogocentric order to disturb patriarchal authority in language and she does this by insisting on “marking the previously unmarked position of masculinity” (ibid: 254). Lacan said that “the phallus can play its role only when veiled” (Gallop 1985: 21), that is, only when appearing to represent everybody, when appearing to be

neutral, thus the identification of authoritative positions as masculine, and not universal, has the potential to destabilise claims to authority. Authority rests precisely on the appearance of neutrality. While the embodied practice of rural nurses challenges claims to a single authoritative view of primary health care knowledge, so long as this embodied knowledge remains unspoken, the challenge can be contained. The strength with which advanced nursing practice is fought in some quarters (as has been highlighted in previous chapters) indicates a type of fear of ‘rupture’ of a predictable phallogentric symbolic order by what some see as the potentially unpredictable, dangerous ‘other’. Kristeva (1997) speaks of the way that the semiotic, subordinated in the formation of the symbolic, continually shadows the symbolic and threatens it with rupture.

The process of ‘unveiling’ the phallus is, again, not a simple one. There have been many challenges to the authority of biomedicine, therefore this challenge should not simply be constructed as an incursion from nursing, but part of the wider suspicion of biomedical knowledge and claims (see Illich 1975, for example). Furthermore, in New Zealand, the profession of midwifery has re-claimed the majority of maternity care (Tully 1999; Tully and Mortlock 1999). These concerns about the claims of biomedicine are part of wider public anxieties about the technological imperative; concerns that become obvious in issues such as genetic engineering, weapons development and heightened awareness and anxiety about environmental degradation. Within the health care arena in recent times a plethora of alternative therapies have emerged that challenge the hegemonic status of biomedical knowledge (Gesler and Kearns 2002; Richardson 2004). But it is the issue of authority that comes to the fore in any challenge to dominant knowledge systems. By their very labels ‘alternative’ and ‘complementary’, these therapies and practices that challenge

biomedicine are located in relation to a biomedical norm. Winnick (2005) notes of CAM (Complementary and Alternative Medicine) that there has been a transition in the ways that these therapies have been talked about in five prestigious medical journals in the United States that signals a shift from a concept of ‘quackery’ towards ‘complementarity’. Being unable to ignore the increased consumer use of these therapies, “physicians began learning to work around or administer CAM, and the subjugation of CAM to scientific scrutiny became the primary means of control” (Winnick 2005: 38). This colonisation highlights the extraordinarily adaptive nature of dominant knowledges such as biomedicine and the difficulty of shaking these knowledges from the outside. Indeed, as Gallop argues that:

one can effectively undo authority only from the position of authority, in a way that exposes the illusions of that position *without renouncing it*, so as to permeate the position itself with the connotations of its illusoriness, so as to show that *everyone*, including the “subject presumed to know” is castrated (1985: 21. Italics in original)

The complex task identified by Gallop, and reiterated by Bondi (1997), of undoing authority from a position of authority involves challenge from within, which Gallop suggests does not then renounce the position. Gallop’s ideas here suggest that it is only from within the authoritative position of biomedicine that the illusions of that authoritative position can be identified without renouncing the position. Seemingly Butler’s (1992) useful argument that to deconstruct something is not necessarily to dismiss it (which I have always found very helpful) leaves out the question of who has the authority to actually perform the act of deconstruction.

The need to be in a position of authority in order to challenge authority could, potentially, exclude nursing from identifying some of the unspoken assumptions that provide the ground for biomedical dominance. Yet although nurses are constructed as ‘other’ in the health care encounter, they do share and utilise biomedical languages.

Therefore, the ability to deploy the language of biomedicine in new ways may just provide a gap into which some intervention is possible and some understanding may be gained of the ways that subjugated knowledges such as nursing can come to unsettle the apparently firm and unambiguous foundations of biomedical knowledges.

Rose (1993:15) articulates a similar project in regard to her position in relation to geography, saying that she adopts a ‘mobility’ that allows her to “resist the closures of masculinism’s exhaustiveness .... by playing with the powerful, by knowing their language and juggling with its possibilities – it is a strategy enabled by intimacy with masculinist geography”. Although nurses may not always be able to claim ‘intimacy’ with masculinist biomedicine, many will be able to claim familiarity and the majority of the nurses who participated in this research acknowledged the need to ‘learn the language’ if they were not already familiar with it. Always remembering the proviso that this biomedical language will not be sufficient as a means of representation of what nurses do.

#### Unpacking the making of clinical knowledge in practice

How is it that practitioners come to ‘know’ and from this knowing develop knowledge that comes to be articulated in language? Many commentators have struggled to articulate the connection between knowledge acquisition and deployment, and practice (Bourdieu 1990; Schön 1982, 1987). Schön (1982, 1987) has written about questions of professional knowing that serve to undo the utility and descriptive power of technical and scientific understandings of knowledge and practice. Within the scientific, technological paradigm it is assumed that practitioners make clinical decisions based on the idea that “practical competence becomes professional when its instrumental problem solving is grounded in systematic, preferably scientific knowledge” (Schön 1987: 8). In so far as research indicates that only about 50 percent

of medical problem solving is based on science (Editorial, *British Medical Journal* 2004: 927), this represents an interesting example of discourse constructing what it purports to name.

A key problem with the technological imperative is that in a system that reduces health and illness to a series of problems that will be solved, either now or in the future by technological solutions, the logical outcome is that physicians could become non-thinking extensions of their machines (Frankford 1994). There is a great deal more going on in practice than the relatively simple application of already known scientific knowledge (Schön 1982) or a blind adherence to the dictates of technology. Atkinson (1995), for instance, in a study of haematologists at work found that biomedical decision-making consisted of a combination of factors including discussion and debate with colleagues, which played a large part in diagnosis. Rather than a machine-like application of already-known scientific knowledge, the haematologists formed diagnoses reflectively and collaboratively. Atkinson's analysis fits with the earlier suggestions made by Schön (1982) identified as to the means by which professional knowledge is made.

Within the technological imperative, units of health care service must be quantifiable to be recognised. Thus the cognitive and caring activities, which are extremely difficult to measure, are marginalized (Frankford 1994: 777). Furthermore, as I shall show later, silencing these more qualitative aspects of health care decision-making and practice becomes a necessary tool in the protection of authority and credibility. In psychoanalytic terms the feminine, consisting of the qualitative, caring aspects and embodied health care performances, is cast out to the realm of the semiotic in order for phallogentric bio-science to at least appear rational, solid, definite and secure. As Homer, following Kristeva says:

what women share with other oppressed groups within society is a position of marginality with respect to the dominant ideology and language. It is in this respect that women and other marginal groups are associated with the semiotic, as that which is outside the dominant discourse and marginal to it (2005: 119).

These categories are of course never hermetically sealed, and exploring the way that biomedical knowledge is constructed reveals that the apparently secure foundation of bio-medicine in western science tells only one partial and privileged part of the story.

#### Making nursing knowledge

In order to construct a new language nurses first need to be able to bring to consciousness what they know and then articulate it. The nurses interviewed for the New Zealand component of this research laughingly said that they did ‘everything’, but moving this ‘everything’ from a list of tasks and responsibilities, towards a more conceptual understanding of nursing work represents the challenge. The New Zealand Nurses’ Association (NZNA) sees nursing as “a human service, melding the knowledge learned from the sciences with the art of nursing to meet the health needs of individuals and the community as a whole” (1992 no page numbers). The nursing role is one in which:

nurses provide an essential role in the co-ordination and continuity of health care, using their tertiary education, experience and professional judgement to:

- Assess patients’ health needs and help make decisions about the services they require
- Influence the environment which impacts on care and access to care
- Decrease anxiety through education and support
- Educate towards independence and promote wellness
- Plan and implement nursing care
- Provide comfort and relief of pain
- Ensure that care is safe – culturally, psychologically and technologically
- Prevent complications
- Monitor and evaluate responses to treatment
- Participate with health planning and evaluation of services (NZNA 1992: no page numbers).

Reflection on and in practice has been suggested as a means of making nursing knowledge overt. While in medicine the role of reflection on or in practice appears to be implicit, within nursing it has been made explicit. It is helpful to distinguish between the two types of reflection that Schön (1982) identified. Papps (1997: 252) applies these two to nursing; firstly reflection-in-action which is seen as a process where problems are solved during practice, but it can also be a way in which new theoretical perspectives develop. And secondly reflection-on-action which is a retrospective activity undertaken to reveal the knowledge used during a particular action. Papps, citing Street, clarifies how, for nurses, reflection has an empowering role, in that it enables nurses:

To become fully cognisant of their own knowledge and actions, the personal and professional histories which have shaped them, the symbols and images inherent in the language they use, the myths and the metaphors which sustain them in their practice, their nursing experiences, and the potentialities and constraints of their work setting (Street 1991. Cited in Papps 1997: 252).

There are obvious connections in what is required of the reflective practitioner and Foucaudian technologies of the self. These technologies of the self were explored in depth in chapter six, and the connection between, not only reflective practice, but also caring and cultural safety as technologies of the self is highlighted in the New Zealand context by Papps (1997). The requirement for reflective practice follows the nurse into clinical work beyond the formal education programme and is one of the competencies required of the nurse practitioner (Nursing Council of New Zealand 2001: 17). It is unclear how much of the above examination of the self that nurses actually engage in during their everyday clinical practice and this point alone would bear further research.

The lack of 'fit' between the available languages and the everyday practices of nursing work in general is well illustrated by nursing theorist, Benner (2000), and

much of the problematic nature of explaining what it is that nurses do (beyond tasks) relates to the concept of care. Nursing writers and social scientists have been very active in attempting to address the issue of care, and have constructed strong critiques of the notion, while not entertaining a goal of disengaging nursing work from care (see Savage 1999; Benner and Gordon 1996; Davies 1995b; Reverby 1990; Benner and Wrubel 1989). Benner indicates frustration in her attempts to translate what she calls “experiences of attuned and authentic care into scientific and technical language” (2000: 294). The very perceived need to translate the language of care into scientific and technical language indicates the dominance of this way of thinking. Using Heidegger’s critical work on technology and the frames within which technological dominance tends to confine thought, Benner suggests that care is an embarrassment to the “technical control paradigm of health” (2000: 306).

Benner’s frustration with the inadequacy of scientific and technical language for articulating the work that nurses do led her to suggest that:

expert clinicians do not engage in knowledge utilization; they develop clinical knowledge. A practice in this view is not a mere carrying out of an interiorized theory; it is a dynamic dialogue in which understanding is refined, refuted, altered, enhanced, and at the very least filled with nuances and qualitative distinctions that are not captured very well in theoretical terms (Benner 2000: 308).

The development of clinical knowledge as a dynamic dialogue sounds remarkably similar to the process that Atkinson’s haematologists engaged in. But, while paying attention to everyday practices may allow Benner (2000) to make a comment about how nurses might produce knowledge, it does not explain how this knowledge comes to be articulated in language, except to say that it is not very well captured in theoretical terms and the knowledge remains unarticulated. Speaking the unspeakable is it seems no easy task and ‘care’ remains problematic insofar as it appears to be at least partially extradiscursive.

## Bodies and abjection

It is important to go beyond a discussion of care at a conceptual level and think about what care means when attached to material bodies. The unspeakable nature of parts of nursing work rests largely on nursing work's association with body-work and the abject. Nurses are often perceived to have a monopoly on the concept of care, although I doubt that there would be a doctor who would state that s/he does not care for patients. Indeed Fitzgerald (2004) provides a fascinating ethnographic study of a small hospital in the South Island of New Zealand in which different professional groups, including managers, deploy 'care' in different ways, but they all utilise the concept while struggling for "interpretative dominance over the meanings of care" (332). But as I argued in chapter five, nurses have a unique proximal relation to the body and the abject in their provision of care, that marks their practice in ways that of other occupational groups in health care is not, or at least not to the same extent.

Lawler (1991) argues that the body is a problem in western society and she goes on to look at the connections between women's work, body care, privacy and 'dirty' work. Further, as already mentioned McClintock locates nurses as "socially appointed *agents* of abjection" (1995: 72). Abjection is that which "the symbolic must reject, cover over or contain" (Grosz 1989: 73) and involves elements that society deems impure such as menstrual blood, excrement, mucous<sup>45</sup>, vomit and pus which are seen as potentially polluting substances. But even more fundamentally, "excrement and its equivalents (decay, infection, disease, corpse, etc.) stand for the danger to identity that comes from without: the ego threatened by the non-ego, society threatened by its outside, life by death" (Kristeva 1997: 260). The abject is never

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<sup>45</sup> These particular substances are deemed impure in many western cultures, but it is important to recognise that impure substances are at least to some degree culturally specific, for example mucous is not 'impure' in all instances in Māori culture and neither are corpses held in such horror.

rejected, covered or contained to the extent that it ceases to be a threat to the subject hence there is the continued possibility of its 'return', a reminder of the materiality of the body and of ultimate mortality. As Grosz (1989: 72) says, "abjection involves the paradoxically necessary but impossible desire to transcend corporeality". Perhaps unsurprisingly those who are associated with the role of dealing with bodies and their effluvia, mothers, nurses, caregivers, funeral directors and so on, by association occupy a curious liminal space that is not quite pure and not quite impure. But then, as Kristeva said, "abjection is above all ambiguity" (Cited in McClintock 1995: 71).

Wiltshire and Parker (1996) argue that nurses need to somehow 'contain' abjection and that they do this during the 'handover' from one nursing shift to another in the hospital setting. The handover is seen as a transitional space where the abject is spoken (signified) and passed on to the incoming nurses, while the outgoing nurses, "having shed it ... can take up their own lives again (ibid: 29).

Thus the body and its care, Lawler's (1991) 'somological practice', presents nurses with a problem even if specific nurses do not actually engage in a great deal of direct body care. By association they risk being over-determined by this aspect of their work. As Lawler states;

nursing involves doing things which are traditionally assigned to females, and learning to do them by experience and practice, but also crossing boundaries, breaking taboos and doing things for people that they would normally do for themselves in private if they were able....body care, as nurses perform it, does not comfortably fit into a logico-positivist framework typical of mainstream science (1991: 30).

But the attempt made in this chapter to highlight the ways that not all of biomedicine fits within the logico-positivist (unveiling the phallus) either, thus creates a gap. Perhaps then, since medicine is usually assumed to draw on already known scientific principles, different dialects of medicine can be observed at work. Perhaps the dialect in which medical knowledge and practice consists of the application of already known

scientific principles is used in 'official' conversations where it is deemed important to signify the 'scientific', 'credible' nature of biomedicine. The other dialect that relies upon cognitive activity, rather than machine like application, to construct knowledge by a process of engagement with other practitioners, reflectively, is a subterranean, usually non-articulated one which never-the-less fuels practice.

### **Questions of credibility**

In the first instance it seems questionable that a language of nursing could compete or even stand alongside the language of bio-medicine given the sheer dominance of that model. As Gieryn says, "boundary-work is brought on by disputes over credibility. Who has the legitimate power to represent a sector of the universe – on what grounds? By what methods or virtues? In which circumstances?" (1999: 340). The questionable likelihood of a credible language of nursing is further damaged by the historical association of nursing with 'women's work'. As Allen says:

To a considerable extent, the difficulties that nurses have in communicating the work that they do, appear to arise from the fact that nursing is women's work and that the multiplicity of tasks that comprise nursing work bears similarities to domestic labour (Allen 2001: 178-179).

Within feminist theorising what knowledge is and who can produce it have been questions of critique for several decades (Code 1991). Women (and by association nurses in a feminised profession) have been constructed as (in)credible knowers (see Ceci 2004 with regard to nurses, and Cupples and Harrison 2001 with regard to abused women). But the desire to construct a language of nursing comes at a moment of possibility that may serve to overcome some of these seeming impediments. If as Gieryn says:

The legitimate right to have one's reality claims accepted as valid or marginally useful is no plum at all if everybody enjoys it all the time.

Epistemic authority exists only to the extent that it is claimed by some people (typically in the name of science) but denied others (which is exactly what boundary-work does) (Gieryn 1999: 14).

Nurses appear to have a corner of the market that may well assist nurses as they claim that they are uniquely placed to deliver primary health care in such a way as to focus on health promotion and preventative strategies. This claim may shift government and policy perception of nurses' 'epistemic authority'.

Papps (1997) says that nursing has been defined as “... a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situations” (New Zealand Nurses Association 1984: 3. Cited in Papps 1997: 256). But perhaps it is the need to meet the market in order to consolidate the position of nursing, that is at the core of the lack that Watson (2004) highlights. Watson notes that caring, having had a central place in the way that nursing has been defined in New Zealand is, “surprisingly absent from the Council’s [Nursing Council of New Zealand] description of nurse” (2004: 14). Perhaps this is one of Bourdieu’s ‘mechanisms of censorship’ by which he means not censorship in the commonsense understanding but rather censorship in the form of self-censorship, where “if one wishes to produce discourse successfully within a particular field, one must observe the forms and formalities of that field” (Bourdieu 1991: 20). The forms and formalities of the field of health care are dominated by biomedicine so perhaps it is simply strategic to leave the word ‘care’ out, as biomedicine tends to do.

Foucault (1980) argued that it is possible to emancipate historically subjugated knowledges and also to reactivate local, minor knowledges in opposition to the scientific hierarchisation of knowledges. Just highlighting the existence of such subjugated knowledges does not necessarily disturb the status quo, although simply

bringing an alternative knowledge to attention does make available an alternative position, and perhaps the task is just this modest. But, there must be sets of conditions surrounding the bringing to the fore of subjugated knowledges for them to ever be anything other than curiosities, or items of derision. It remains an open question as to whether the subjugated knowledge of nursing is brought to the fore in its entirety or if it is mainly that part of nursing that meshes with current government objectives in health care that becomes understandable.

#### Strategic positioning: Meeting the market

In the contemporary health care context in New Zealand a moment of possibility arises, at least in part, due to a particular convergence of factors. These factors are firstly, sympathetic government health policy, with its focus on innovative means (including a greater contribution by nursing) of delivering, improving, and containing cost in primary health care. The second is the increasing and overt attention to preventative care and health promotion, both of which nurses claim to be uniquely equipped to deliver. This shift in focus also sits alongside an increasing recognition of the effectiveness of utilising feminised attributes in order to achieve behaviour change in organisations, and health care should be no exception to this. These first two are very closely related and will be discussed below together. And thirdly, the introduction of new legislation in the form of the HPCA Act, which, in spite of the difficulties in defining scope of practice for rural nurses, simultaneously provides a backing in legislation for extended/expanded nursing practice, once these issues are resolved. The HPCA Act is not discussed here as it has already been addressed in the context of chapter four. All of these place nurses in a potentially strong position politically.

The current strength of nurses' political position is evident in the recent successful pay claim, settled on December 16 2004, and ratified by members of the New Zealand Nurses Organisation (NZNO) in February of 2005, met all pay claims for public hospital nurses and was based on benchmarking against other state sector professional and overseas nurses (NZNO 2004). In a keynote speech to the New Zealand Nurses Organisation Annual General Meeting, President, Jean O'Malley said that nurses were "no longer prepared to be the respected but disregarded profession" and they would not wait for fair pay (2004: 1-2), while Nurses Organisation spokesperson Laila Harrè said that "the angels of mercy are mad as hell" (Harrè 2003: 2). Nurses rank consistently highly in terms of public confidence in the regularly conducted UMR polls<sup>46</sup>. Drawing on this already known public support, the Nurses Organisation conducted a national petition to assess if the public supported nurses' claims to gain fair pay and safe staffing. About 125,000 signatures were collected. During the fair pay campaign, nurses argued that problems with recruitment and retention of nurses, which has led to a worldwide shortage, could be mitigated by improved pay rates. Importantly for the purposes of this thesis, primary care nurses were not included in the fair pay claims and the NZNO is currently organising a Pay Parity for Primary Care campaign (Harrè 2005: 3). Harrè, in discussing the positioning of nurses in relation to the *Primary Health Care Strategy*, also raises questions about:

whether the beliefs, expectations and values underpinning the primary health care strategy and the rhetoric around them is fundamentally at odds with a continuation of the small business ownership model for the vast majority of primary health care services – GP practices – and the consequent right of the owner to determine the distribution and uses of practice income. Is there a contradiction between the requirements of professional partnerships between doctors, nurses and other health workers and the employment of nurses by doctors?

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<sup>46</sup> UMR is an Australasian research company that conducts issues research.

Those rural nurses who are employed by District Health Boards are presumably covered in the ‘fair pay’ gained for hospital nurses, but if the model of rural nursing was to extend into urban areas, or expand in rural areas, how nurses are employed is a crucial question to address.

#### Shifting the focus of health care and involving nurses

This investigation is located within a political climate of on-going health sector restructuring, including the formation of Primary Health Organisations, as well as a will to pay more attention to the contribution that nursing can make to primary health care (see *Report of the Ministerial Taskforce on Nursing: Releasing the Potential of Nursing* 1998), and within a worldwide acknowledgement of the importance of shifting the focus of health care from an ‘illness’ to a ‘wellness’ model of care.

Nurses argue that they are uniquely placed to deliver ‘wellness’ focused primary health care so there is a convergence between Government and nursing goals.

According to the Ministerial Taskforce on Nursing:

the nursing concept of health includes the impact of culture, gender and socio-economic status on both people’s understanding of good health and their access to it. Key areas of nursing involve working alongside people to teach health and safety practices, and helping others to maximise health in difficult circumstances (1998: 21).

In some sense it seems as if the wheel is reinvented as this desire to ‘teach health and safety’ sounds very similar to the arguments that were made in favour of native health nurses in chapter three. Some of the principles of the nurse practitioner role are also that “nurses work towards health gain to address and reduce inequalities and inequities in health. In the New Zealand context this means addressing the health needs of Māori and Pacific peoples” (Nursing Council of New Zealand 2001: 12).

The heightened awareness of the contribution of nursing is made very concrete in the *Primary Care Strategy*, the Expert Advisory Group on Primary Health Care Nursing, said that:

The extensive contribution that primary health care nursing can make to reducing health inequalities<sup>47</sup>, achieving population health gains and promoting and preventing disease is yet to be fully realised. The Primary Health Care Strategy is intended to achieve this. The Strategy was released in February 2001 and identified primary health care nurses as crucial to its successful implementation. It required the Ministry of Health to facilitate a national approach to primary health care nursing which addresses capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements (*Investing in Health* 2003: vii).

The recognition in the Primary Care Strategy that nursing can play a crucial role in primary health care provides an opportunity for “significant culture change, with nursing repositioning itself for new ways of delivering services in primary care settings and communities, so as to more effectively improve the health of New Zealanders” (*Investing in Health* 2003: vii). The language used in the above quotation where ‘significant culture change’ and the word ‘repositioning’ seem to imply a sense of recognising and taking opportunities that present in the new health care climate. This ‘culture change’ is not a radical departure from a sense of what nursing is, but recognition of a shift in the structure of primary health care delivery previously dominated by the biomedical model. In fact I heard one general practitioner lament that the word ‘doctor’ was not used once in the Primary Health Care Strategy although I have not checked this as a piece of ‘factual’ information, the doctor’s perception is what is important here in that it signals her recognition of a ‘culture change’.

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<sup>47</sup> In the United States the Nurse Practitioner role was set up in the 1960s in order to help address health inequalities by providing a different model of health care that “adds caring to curing” (Fisher 1991: 157).

Part of this change is toward the possibility of extended nurse-led services. The Expert Advisory Group identified two different models of nurse-led primary health care practice. The first is a settings approach where nurses provide “comprehensive generalist care to a defined population as the primary health care provider in collaboration with others”, which has developed in “the absence of other appropriate health professionals or providers” (*Investing in Health* 2003: 25). The second approach is a specialist approach where practitioners focus either on one disease state, specific condition or population group. “These services also focus on early detection and intervention, and thereby increase the client’s ability to self-manage chronic illness and prevent avoidable admissions to hospital” (ibid: 26). The first model presented above is most similar to that already provided by rural primary health care nurses.

#### Money talks: Funding

In an effort to recognise and facilitate the contribution of nursing the Ministry of Health has funded eleven projects via the Primary Health Care Nursing Innovations Funding. The available funding pool is \$8.1 million between July 2002 and July 2006. Of this figure, \$850,000 has been available to nurses in order to fund scholarships for nurses working in primary care to complete a postgraduate paper, or undertake a course of postgraduate study relevant to primary health care nursing (MOH 2002b: 1). Nursing Innovations are discussed first, followed by the postgraduate scholarships.

The only innovation to receive funding in the South Island has been the Neighbourhood Nurses project based in Reefton in the Buller district which is the most economically deprived district in the South Island. Project leader Michele Barber sees the project as one that is likely to decrease the fragmentation of nursing

services, and she sees the project as one where a “team of neighbourhood nurses would work with individuals, families, groups and the community, offering a mix of generalist, specialist, expanded and advanced practice” (Conference Report 2003: 17). Another of the initiatives, based in Turangi is developing “a new nursing role that would enable the development of new boundaries and parameters. These whanau<sup>48</sup>/family nurses will be concerned with how people live through their whole health circumstances. They will practise in a new way, creating a new configuration of all services” (ibid). These new initiatives obviously share strong similarities with the FHN role but they are not inserted back into the original practice setting and this could be a distinct advantage. Clearly the funders have been convinced with whatever nursing had to offer in order to commit money to these projects, which are certainly not medical projects.

In terms of the postgraduate scholarship funding, The National Centre for Rural Health operating under the umbrella of the University of Otago and based out of the Christchurch Clinical School, failed in its bid, firstly to have the courses already offered to rural nurses accredited at clinical Master’s level, thus disappointing both those who had designed and delivered the programmes, but also the nurses who had done certificate and diploma work through the centre. An ongoing need for targeted rural health nursing education continued to be acknowledged and the Clinical Training Agency put a Primary Health Care Nursing (Rural), Postgraduate Diploma out to tender. The Institute for Rural Health in Hamilton in conjunction with the School of Nursing in the Faculty of Medical and Health Sciences at the University of Auckland won the tender. In early 2004, the Clinical Training Agency was fully funding the course for rural nurses working in rural health care to undertake the

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<sup>48</sup> Whanau is a Māori word meaning family, but family in an extended sense, including the nuclear family and aunts, uncles and cousins.

Postgraduate Diploma Health Science (Advanced Nursing) focused in Primary Health Care (Rural).

As well as this initiative, the Ministry acknowledged that the nurse practitioner role is expected to “provide a solution to rural workforce shortages and relieve pressure on existing rural health practitioners ... but various factors, such as geographic isolation, are acting as barriers to rural nurses achieving the requirements for approval by the Nursing Council as nurse practitioners” (Hughes 2003: 1). As a result of these concerns a funding package was introduced specifically targeted at rural nurses who only needed one year of study to enable them to complete the requirements for their applications for nurse practitioner status. A total of \$240,000 was made available over 2003/2004 and 2005/2006 to cover up to six nurses’ salaries while they engaged in a year’s full-time study and assistance with fees and travel costs was available from the primary health care nursing scholarship fund. District Health boards are expected to employ locum nurses with the salary savings (ibid).

#### Barriers to listening to the language of nursing

In spite of this obvious fit between nursing ethos and government policy, the Ministerial Taskforce on Nursing, indicated barriers to the realisation of the potential of nursing to contribute to health care. In describing what nurses do, the Ministerial Taskforce became aware of a “gap between what nursing is in its intent and theoretical foundation, and the degree to which that potential is lost because many practice settings [remain] ... powerfully influenced by medical definitions and outcomes” (1998: 21). At a meeting held in Christchurch in 2003, which was to discuss advanced roles in nursing from a number of viewpoints, one of the presenters was Christchurch general practitioner Pippa Mackay said that she found it very

difficult when ‘her’ practice nurse<sup>49</sup> was away since it was much easier to work with someone whose practice you know. While she was sympathetic to groups wanting to up-skill, she was concerned about issues of safety if nurses took on more responsibility and the fact remained, she said, that she paid her practice nurse’s wages, she paid for the supplies and equipment that the nurse used, as well as paying for the rent on the clinic rooms out of which the nurse worked. I had a clear sense of a notion of ownership of the nurse, who was seen as a helper and wondered what the practice nurse herself might have said in response. I have no doubt that there are a substantial number of nurses who are happy enough with the above type of working arrangement but it reinforces the Ministerial Taskforce’s concern about employment structures that may inhibit the full use of nursing skills. While nurses are employees of doctors, there will be barriers to their practice. Several of the rural primary care nurses in this study commented that they would not be interested, if they remained in primary care work, in taking up jobs where they were employed by doctors. The independence and lack of competition for patients were perceived very positively.

With the new Primary Health Organisation (PHO) structure in New Zealand nurses should also be in a strong position to contribute in a more significant way within primary health care. While in many areas nurses will continue to be employed by District Health Boards (DHBs) to provide health care services in outlying areas, the more usual structure of primary health care delivery in towns and urban areas remains that based around the existing medical practices. These practices have recently been subject to a round of restructuring in which a new structure, the PHO, has been introduced. The vision for these structures, which are being put in place at present, is that they will achieve “results in terms of better health, reduced health

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<sup>49</sup> In 1999, the New Zealand government was spending \$30 million dollars per annum in subsidies to doctors to employ practice nurses (Carryer et al. 1999: 2).

inequalities and easier access to services” (King 2001: 2). One of the six key points about PHOs, unlike their predecessors Independent Practitioner Associations (IPAs), is that they “must demonstrate how *all* their providers and practitioners can influence the organisation’s decision-making” and the District Health Board “must be satisfied that the PHOs seek the views of providers and practitioners and have sufficient processes to ensure that decisions take account of a range of views” (King 2001: 4. Emphasis mine). This insistence on including the views of all practitioners, not only medical ones in the decision-making process within PHOs clearly makes room, officially, for a nursing contribution but Hansen argues that while nurses welcomed the “notion of shared governance between nurses and doctors in strong community partnerships ... this has not been realised in the establishment of all PHOs” (2004: 2).

While O’Connor cautions against casting doctors alone as “the traditional power holders”, she also wants to point out the role of the Ministry of Health which she says “wields a lot of power that is not always in nursing’s best interests” (2003b: 2). She goes on to state that the:

NZNO [New Zealand Nurses’ Organisation] is angered by an arrogance within the ministry that allows decisions about nurses and nursing to be made with no direct input from nurses. The list of such instances is lengthening: the development of cancer treatment guidelines by the ministry, including recommendations pertinent to nursing, without input from the chief nursing adviser; The lack of visibility given to the work of nurses and the chief nursing adviser during the SARS outbreak; the fact the chief nursing adviser is not a member of the ministry’s PHC team and cannot attend its meetings without the team’s permission and yet the PHC strategy states nursing is crucial to implementing the strategy (ibid).

With the current focus on community consultation it is curious that consultation with nurses is not seen to be necessary or is carried out as what O’Connor (2003b) calls “Clayton’s consultation”, that is as a pale shadow of any real effort to consult. Meerabeau (2005: 129) also notes the embeddedness of medicine within the Department of Health and the lack of influence that nurses have had in the health

policy setting in the United Kingdom, saying that (following Scott 1994) “nursing has often not known how to play the policy game, or even what game was being played”.

A final barrier may have been that over the confusion surrounding liability. It has been mistakenly assumed that medical practitioners carry medico-legal responsibility for nurses, but under the Nurses Act 1977 nurses are fully responsible and accountable for their actions. The belief that doctors carry medico-legal responsibility for nurses may have contributed to the notion that the patient in some sense ‘belongs’ to the medical practitioner throughout all stages of treatment and care (Ministerial Taskforce on Nursing 1998: 21). This view promotes two outcomes, the first is that there is no autonomous and valuable (in health terms) contribution that nurses make and the second is that whatever interventions or education are deemed necessary must be led by the medical practitioner. A sense of ‘natural’ medical leadership extends “into the broader areas of health promotion and health maintenance, even though these are not a significant aspect of medical education and training” (ibid). Releasing nursing from the umbrella of biomedicine is necessary if this potential contribution is to be realised and one of the crucial tasks is the articulation of the difference that nursing makes to health care. This articulation requires a language that is convincing and understandable to those outside of nursing but it needs to be borne in mind that this project is much more complex one than a simple process of emancipation based on modernist notions of power (Papps 1997).

### **Inserting nursing into technologies of government**

The promise of proximal practitioners

One of the key contributions that nurses make to health care rests on their proximity to the patient (but see Malone 2003 with regard to the ways that some nursing is becoming more ‘distal’). To some extent it could be argued that the closer a

practitioner is to the patient the more difficulty they will have quantifying what they do (how do you talk about the conversation with a patient about their leg ulcer over the bananas at the local shop?). Further, while nurses reported that patients expressed concern about not wanting to ‘bother the doctor’ (see also *Nursing for Health* 2001: 9), many of them find nurses more approachable although patients do not always understand the role of the nurse. Problems with role understanding were noted by FHNs in the Western Isles, as was also the case in research with hospital patients where there was a lack of understanding of the role of the nurse within the multi-disciplinary teams. Fielden’s research (cited in O’Connor 2002: 28), found that “patients felt that nurses were great but I think the profession has some work to do to ensure its professional contribution to care is recognised and understood. The invisibility of the work of nursing was pervasive”. The perception of nursing work as invisible is all the more interesting given that nurses are the health care practitioners who spend the most time with patients. Doctors in primary care spend a limited amount of time with patients. With this time limitation, there is less opportunity to facilitate preventative and health promoting education. In the main nurses simply spend more time with patients. There are structural factors that make this more possible such as the fact that in New Zealand nurses mainly work as employees and doctors in private practice do not, but are small business owners.

But beyond this simple point, which may just seem as though I am making an argument for doctor-nurse substitution, nurses in rural primary health care claim to offer both more and less than medicine. While medicine is expected from doctors, rural primary care nurses provide some things which are usually the province of medicine, but also nursing. The difficulty of thinking outside the biomedical model is evident in the ways that the ‘substitution’ of doctors with nurses is talked about.

Richardson and Maynard (1995) reviewed the knowledge base currently available for doctor-nurse substitution. Their monograph identified shortcomings in all of the studies available at that time (1995). While the shortcomings that they identified in the already published studies were quite significant, their own analysis also exhibited a very singular viewpoint. Drawing on their review of the literature, Richardson and Maynard suggest that anything from 30 to 70 percent of the tasks performed by doctors could be carried out by nurses, and they criticised some of the studies for not taking into account the different amounts of time that doctors and nurses might take to carry out the same tasks. This criticism is firmly located within a biomedical model of care and fails to acknowledge that nurses will also ‘nurse’ when they carry out tasks previously carried out by doctors. The type of analysis carried out by Richardson and Maynard serves to render invisible the ‘nursing’ contribution made by trained nurses and again raises the, well documented, problematic nature of measuring and articulating nursing work.

The crucial point is that nurses claim that they bring a different kind of practice, what they claim to be more ‘holistic’, comprehensive and thus less fragmented (but see Lawler 1991 for a critical analysis of the meaning of holism). Continually pointing this out is important because nursing knowledge, particularly as it is enacted in rural areas, is often reduced to a mini-medical, rather than maxi-nurse definition. Reducing the contribution of nursing in this way does not do justice to what it is that nurses say about their practice, that it is simultaneously more, and less than medicine. But it is perhaps just this hybrid form that can provide the most appropriate first point of contact primary health care in the contemporary moment, at least in some locations.

Are we ready for the language of care?

The recognition of a moment of possibility, with a relatively sympathetic view of the contribution of nursing in official circles raises questions about whether the neo-liberal political system, with its focus on individual responsibility and community care in which we are embedded is ready to take account of care work overtly. Or is it simply that there is a recognition that nursing can carry out some tasks that those that govern health have defined as important? In a recent article McDowell (2004), argues that 'care' remains marginalized in very fundamental ways within the mentality of the neo-liberal state. This marginalisation may be part of the reason that Parr (2003) notes a relative lack of attention to care and caring in medical and health geographies. McDowell (2004) argues that the marginalisation of care is manifest in the simultaneous imperative to engage in paid work for all while there is a lack of acknowledgement of the need to provide appropriate child-care to make this wholesale move possible. This continuing disjuncture only serves to render care work, unpaid in this case, invisible, unimportant, below the radar screen of government policy. While not arguing that her analysis brings care work to national attention, the work of Cupples (2005) does complicate any simple trajectory for care work under neoliberalism. The post-revolutionary Nicaraguan women in Cupples' study renegotiate their gender identities as they engage in paid work, while "holding on to caring subjectivities" (2005: 320). Instead of taking up a double or triple burden where they engage in both paid work and unpaid care work, these women draw on local networks to free themselves from domestic labour. While making sense of their contribution to the family in perhaps more 'masculine ways', the women still construct what they do as 'care' (Cupples 2005).

While it is important to continue to challenge the type of problematic that McDowell notes above, more strategic use of language may be more effective, at least in the west. If language is performative (Butler 1997b), the language of care may not then ‘work’ in the face of a political climate that cannot recognise the terminology.

Yet, this is also a climate in which ‘feminisation’ has been identified as a phenomenon in the contemporary labour force. In fact McDowell (2003) argues that certain types of masculinity are becoming ‘redundant’. Fondas (1997: 258) identifies three different types of feminisation. The first type, feminisation of the labour force, addresses the rising rate of female participation of the work force, while the second looks at the feminisation of certain occupations. But it is the third form that is of particular interest here with this form being defined as “the spread of *traits or qualities* that are traditionally associated with females to things and people not usually described that way” (Fondas 1997: 258. Emphasis in original). Fondas explores the implicit feminisation of managerial work, including the shift away from seeing this work as to “command, direct, and control [but to] grow, nurture, and teach” (1997: 265). Fondas is interested to explain why it is that this process of feminisation goes unnamed, and she does so by suggesting that to say a particular mode of managing is feminine, simultaneously means that it is not masculine which is a gendered positioning that would not be acceptable to many managers. To extrapolate from Fondas’ argument and assume that a similar desire or need for more feminised ways of working may be evident beyond the arena of management has productive resonances in health care. The ostensibly feminised capacities where a manager is teacher, mentor, and resource developer of human potential (Fondas 1997: 259, citing Naisbitt 1985: 60-61), should be familiar by now as notions deployed in the delivery of primary health care by nurses. These gendered attributes may thus be mobilised in

the service of the state, but it is questionable what happens when these feminised capacities already belong to a feminised profession such as nursing. Perhaps they are merely harnessed and redeployed, rather than signalling any fundamental change in how the state perceives care.

The cynical part of me is concerned that while the sympathetic climate offers an opportunity for nursing to firmly establish a politically recognised place in primary health care<sup>50</sup>, pressures for cost constraint in health expenditure may be at least part of the driving force behind the focus on nursing. Frankford argues, in the face of the perceived cost crisis in health care, that the discipline of health services research that relies on neoclassical health economics may serve to “reinforce the strength of biomedical positivism and the concomitant technological imperative” (1994: 773). The technological imperative looks for “technocratically conceived solutions for political problems” and ignores the cultural dimensions of the problems at hand (ibid).

While I am unwilling to dismiss Frankford’s argument out of hand, it is useful to remember there is a certain level of reductionism (strategically mobilised) in the deployment of ‘pure’ biomedical positivism. As was indicated in the discussion regarding the ways that medical knowledge is constructed, the process is far more complex than the simple application of already known knowledge, but rather the relational construction of knowledge in, and from practice. It has proven to be politically useful to utilise the part of the language of biomedicine that ‘works’ in order to consolidate a mandated place within health care. Conventional biomedical knowledge has been called to account in recent years and the push towards ‘evidence-based practice’ has gained momentum, further indicating that anything said by or on behalf of medicine is not inherently ‘correct’ or valid knowledge, but requires systems

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<sup>50</sup> Always bearing in mind the ambivalent position that nurses come to be located in if their focus comes to be predominantly on health promotion as was discussed in the context of critical approaches to public health in chapter seven.

of authorisation. Perhaps it is this leaf from the book of medicine (using a language that ‘works’) that nurses could re-work for their own purposes in ways that, in general, nurses have been somewhat reluctant to in the past. As Carryer, Professor of Nursing at Massey University says:

Nurses have so much to learn still about the use of power. We have to grow beyond waiting for and asking for permission. It will never be given as the dominant group has too much invested in keeping us on the margins. Our power comes from knowing that people need nursing more than ever. We must assume this power and run with it! (Carryer, Cited in Adams 2003: 306)

The waiting for permission may well have been a ‘habit of gender’ (Adkins 2003) that has contributed to the relative invisibility of the difference that nursing makes to health care. The very fact that the clear majority of the rural nurses that I talked to were doing advanced study signalled something about their relationship to their identity as nurses and their practice. Perhaps rather than lacking a coherent sewn up nursing language that articulates care in all its complexity, we should be focussing on the different dialects that are needed in different situations, the very value of nursing is its flexibility and hence a flexible language is needed. As Allen says:

Attempts to fix the nursing role too rigidly are doomed to fail; the content of nursing practice ... is forever changing, both historically and in daily practice, and will continue to do so. This is its strength. However, if nurses are to shape and reshape their bundle of work activities in order to maximize the benefits for patients, then the challenge for the occupation is to establish empirical evidence of the nursing contribution and a vocabulary through which this can be communicated and incorporated into the educational process (2001: 179).

### **Concluding Comments**

Both rural primary care nurses and doctors practise their respective professional work at a distance (literally and metaphorically) from the centres of technological control, thus the everyday work practices of rural and remote practitioners challenge the utility

of the technological imperative in primary health care. Furthermore, nurses' positions have always been authorised within a certain frame (particular positions in wards for example) – rural nurses escape that frame as do other nurses who extend their practice – they thus become a threat to the boundaries of authorised knowledge and perhaps space.

Though nurses in rural areas currently and those who work as first point of contact in the health care system in urban areas, should this even come to pass, may use some of the language of biomedicine, they do so in a complex way. Keyzer (2001) was concerned that taking on 'medical' tasks would change nursing into another occupational role and in some sense promote the colonisation of nursing by medicine. Nurses themselves insisted that what they did was not mini-doctoring, but maxi-nursing so rejecting conclusions such as Keyzer's.

Perhaps nurses are condemned to be bilingual, to be required to function in two worlds that are not completely separate but require different language systems to articulate their meaning. Perhaps condemned is not the right word, since those who speak more than one language may benefit in personal terms from the different ways they can function in the world as a result of their movement between language realms. It could be that one of these languages remains subordinated, as do indigenous languages in colonised countries. Or, alternatively, two distinct languages may not remain, but a form of health care 'pidgin' could be produced as may be the case with the recent Australian moves to consider a doctor-nurse hybrid. This proposal to introduce a specially trained doctor-nurse hybrid is designed specifically to address health care needs in rural communities (Cresswell 2005). Interestingly the Australians have not followed the model of the physician assistants as used in the United States,

presumably recognising that there is a specificity about the nursing contribution that is important to protect.

But, if for a moment we consider nurses to be at least potentially and partially colonised subjects, even then there is no simple mapping of what is medical onto nurses' practice. Campbell and Harbord (1999), using Bhabha's work suggest a relationship of 'mimicry' between colonised and coloniser. This mimicry is neither "the subversion of the colonial subject nor an identificatory collusion with him [sic], but remains ambiguously along the spectrum between these terms" (Campbell and Harbord 1999: 235). While acknowledging similarities with Butler's performative in the recognition that the "dependency of the dominant on reiteration and repetition is also potentially the point of instability", but Bhabha's account goes further in that it "can be read to suggest a difference that cannot be signified at all within the dominant terms and which will always remain a threatening possibility and indecipherable presence at the edges of the dominant discourse" (Campbell and Harbord 1999: 236).

Nurses appear to suggest that while they use medical language, their practice is not reducible to biomedicine, but contains a 'difference' that cannot be signified within the terms of the dominant discourse. Perhaps then Keyzer's concern, while important to pay attention to, is not, in practice, a problem, since nurses maintain identities as nurses by their own definition. Furthermore what nursing is, just as what medicine is, remains in flux.

Acknowledging that rural nursing needs to develop a language to talk about itself means that the process is already happening, since if we follow Butler (1997) then what we speak of, concomitantly constructs that of which we speak. If we take into account the initiative of the National Centre for Rural Health in describing rural nursing scopes and contexts of practice, and similar efforts for the purposes of the

Health Practitioners Competency Assurance Act and the role of nurse practitioner, then we can see that there are already ways of talking about nursing, even rural nursing that did not exist ten years ago. In many ways the process that I have engaged in here is one of highlighting what is already happening in developing a language to talk about rural primary care nursing rather than to construct something radically new. This task is very similar to that which Halfacree (forthcoming) engages in when he says he brings together those things that are already known about rural space, rather than revealing something new, hidden or lost. Systematically discussing what is already there consolidates current knowledge and often surprises in the sheer quantity of what there is already there to work with.

The problem has not only been the need to construct a new language, but the need to, firstly bring to consciousness embodied practice, and then articulate what it is that nurses do before this can even be articulated in language, but the second key component is that what comes to be articulated needs to be inserted into a system in which it can be understood. Therefore the task is to find ways to talk about nursing work that clearly show the ‘difference that nursing makes’. This may need to take the form of reporting of evidence-based nursing interventions, and quite probably will mean just that, since in a culture of audit and accountability nothing less is understandable.

In the face of a longstanding suspicion on the part of some nurses about academic work about nursing and nurses who have ‘defected’ to become academics, a much closer collaboration would seem to be in the best interests of nursing and its need to articulate some dialects that become understandable to policy makers. Working strategically in this way need not alter what nurses hold to be crucial to nursing. Rural primary care nurses provide an example of the way that nursing can be

performed, and even in spite of the taking on of some so-called medical tasks, remain consistent with individual perceptions of professional nursing identity.

The contemporary health care environment, in spite of the barriers identified above, provides an ‘encouraging’ space into which a more fundamental role can be imagined for nursing as the first point of contact in primary health care. While it would be ridiculous to suggest that there was no longer a need for general practitioners, it is useful to question if it is they who should remain the first point of contact in the health care system, particularly one that current policy wisdom wants to reorient towards a focus on prevention and health promotion, rather than simply ‘cure’.

### **Concluding Comments: Does the rural lead or follow?**

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Using the notion of nurses as a 'stop-gap' in the provision of rural primary health care until problems with recruitment and retention of rural general practitioners are addressed, is a rhetorical device that facilitates the under-analysis of the role that nurses play and the contribution that they make. This rhetorical device also masks a type of nostalgia for an imagined time when professional roles were ordered, certain and bounded and doctors and nurses knew their respective places. This certainty about role boundaries has been challenged by the embodied practices of rural nurses for as long as there have been doctors and nurses in rural areas in New Zealand. It is redundant to conceive of rural and remote comprehensive nursing roles as a stop-gap over a hundred years after they first appeared, thus clearly the risks of full acknowledgement of what these roles contribute are high. Alongside the challenge that the embodied practice of rural nurses presents to traditional notions of primary health care provision is a silencing, and a lack of discursive space in which to articulate practice. This thesis plays a part in both identifying and understanding the lack of discursive space, and suggesting ways of cutting through the silence. The task of this final chapter is to discuss both the theoretical and practical implications arising from the research detailed in this thesis.

As a feminist social researcher and as an ex-nurse, this silencing, a silencing that I had my first inklings of when I was undertaking my training, is both understandable in theoretical terms, and unacceptable in personal terms. In this thesis I have attempted to push past this point of understandable/unacceptable to argue for a politics arising from the embodied practice of rural nursing, thus avoiding the relativist tendencies of poststructural theories. Drawing on feminist and critical theories, I insist on an analysis of the potential to, not just understand, but to alter, modify, change, improve, both the understanding of what rural nursing means when it comes to speech and what the implications of this understanding are. Fundamentally I argue that the embodied practices of rural and remote nurses challenge who can be seen as the first point of contact in the health care system, not just in rural areas but everywhere. The very existence of nurses working as the first point of contact in the health care system over time, without provoking undue litigation<sup>51</sup>, and for all intents and purposes who appear to deliver an appropriate service, raises serious questions about who can claim the right to be a primary health care provider.

It was initially tempting to conceive of rural primary care nurses as rural women dependent upon limited rural labour markets. It was also tempting to see their nursing as a highly gendered work performance, in their apparent willingness to be extremely flexible and willing to meet many sets of needs, with nurses being flexible in clinical, spatial and temporal terms. But, the agency exhibited by those nurses who had relocated to rural areas specifically for these broad nursing roles, and the ways that they drew on notions of autonomy and independence to explain this relocation

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<sup>51</sup> The Nursing Council of New Zealand, which is the regulatory body for nurses, keep no records of the differential rates of litigation or censure between rural and urban nurses. When contacted regarding this issue, the legal team and registration manager, Barry Ayling, were prepared to say that subjectively they do not have any impression of a greater or lesser incidence of complaints or investigations of rural nurses. This confirmed my own subjective impression.

disrupted this initial simplistic analysis. In this sense the rural presented a space of professional opportunity, not simply one of constraint.

Rural primary care nurses who relocate to rural areas for work utilise discourses of autonomy and independence to explain their reasons for moving. But these liberties (gaining more professional autonomy, and the opportunity for independent practice) are regulated externally by enduring ideological notions of what it is to be a nurse and discourses of risk and law. At a finer spatial scale, liberties are regulated (Bourdieu 1991) by notions of where interprofessional boundaries lie, and at an even finer spatial scale by the self-governance of individual personal and professional conduct.

Governing rural nurses has relied to a large extent upon them governing themselves in the face of the lack of fit between what rural primary care nurses do and how legislation and governing frameworks are adopted. Within this climate of medico-legal risk, and a lack of fit with legislation, rural primary care nurses engage in technologies of the self that govern their professional conduct. The analysis of nurses' everyday practices shows how they constantly work to render their professional conduct 'appropriate', and their professional practice 'safe'.

In a political and professional climate preoccupied with audit and accountability, confined professional roles embodied in specialisation are simpler to assess for audit purposes. Recently introduced frameworks such as the role of nurse practitioner and the Health Practitioners Competency Assurance Act rely upon confined scopes of practice to enable the measurement of competence. Rural primary care nursing in its breadth was inadequately captured within early attempts to define scopes of practice for the purposes of these new frameworks.

I set out to address three questions in the course of this thesis. The first concerned the ways that nurses currently function to deliver primary health care in rural places. I was not interested in rehearsing lists of tasks, but rather in gaining an understanding of the ways that rural primary care nurses make sense of flexible, generalist professional identities that cross both inter- and intra- professional boundaries and that differ enormously from urban primary health care nursing work. Secondly, I was interested to explore the ways that feminised professional work and rural space influenced each other. And thirdly, I wanted to see if I could assess the potential that the model presented by rural primary care nursing had to translate to the urban environment.

My task throughout this thesis has been to move between the empirical, the theoretical and the personal, having each inform the other, while not overloading one with the other. While I believe it is inappropriate to ‘let the data speak for themselves’, it is also inappropriate to bury the empirical data in impenetrable theory. Thus I have used theory eclectically as I have needed it as an explanatory tool, using poststructuralist, feminist and psychoanalytic theories as necessary. Unsurprisingly, addressing the above questions has resulted in a melding of the issues that arise from each of the questions, so that they come to not be answered separately but meshed together. Each informs the other questions, and one cannot be understood without the others. The theoretical implications drawn out from this melding cover the areas of governmentalising the rural, spatialising law, the power of the abject and different ontologies.

Any investigation of health care in the contemporary moment needs to take account of the influence of biomedical dominance, an increasingly litigious mentality in relation to health care, a shifting focus towards primary rather than secondary

health care, and the positioning and re-positioning of subjects within the neo-liberal state. By examining in depth the sense making practices of rural nurses, I have constructed an understanding of the ways that these nurses negotiate the complex terrain of biomedical dominance and fear of litigation.

The relations between medicine and nursing have historically constructed nurses as subordinate within the health care division of labour. Furthermore, attempts have been made over time to consolidate a very rigid division<sup>52</sup> of labour between medicine and nursing. In the contemporary environment concerns expressed by some doctors surrounding the expanded role of nursing indicate a desire to govern the boundaries of what nurses can do. Nurses themselves also police the boundaries of their practice. This is evident in the comments of those nurses who criticise others who they assume want to be ‘mini-doctors’. Nurses also govern their own personal practice in very complex and reflexive ways. This personal governance represents the most complex and multi-faceted type of individual, personal professional regulation where nurses construct auditable professional identities. This need to construct auditable identities occurs as a response to attempts by some doctors and others to construct nurses as risky professional subjects, thus potentially discrediting the nursing contribution.

### **Theoretical Implications**

#### Governmentalising rural practice

It is in addressing the question of how nurses construct these auditable professional identities that theories of governmentality have been extremely helpful in thinking through the governed and self-governing gendered selves that nurses voluntarily

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<sup>52</sup> Interestingly, divisions within health systems are becoming more blurred, for example the treatment of ‘public’ patients in ‘private’ hospitals.

construct. While Foucauldian inspired theories of governmentality are now widely used in social science, they have been slowly taken up by geographers conducting rural research. Indeed, Woods (2003: 258) has lamented that “theoretical concepts such as governance, regulation and governmentality tend to have been applied to rural situations rather than developed in rural contexts”.

While I have used the theory of governmentality to think through the complex positioning of rural primary care nurses, this is no simple mapping exercise. While all health care professionals can be argued to engage simultaneously with technologies of power and technologies of the self in order to construct appropriate professional identities, the form this takes in the rural environment is instructive. In a sense the rural becomes a laboratory for the investigation of the, often gendered, limits of the governing and self-governance of professionals. In the absence of direct proximity with other health care providers, rural primary care nurses are both governed at a distance by technologies of government and govern themselves by utilising technologies of the self. The resulting professional identities elicit ‘reliable’, ‘appropriate’, ‘safe’ performances of professional primary care work, at a distance, as much as this can even be guaranteed.

But most importantly this work crosses conventional inter- and intra-professional boundaries. Nurses actively work with their practice at the boundary, in some sense, to domesticate it, to render it coherent within the terms of what nurses consider to be nursing, even if that expands their own definition of what nursing is. This active engagement at the conceptual point of intersection between technologies of power and technologies of the self, embodied in the concept of governmentality, is in rural primary care nursing, a point of production of boundary-contesting

professional identities, not simply a point of control. Feminised professional identities and rural spaces together co-construct hybrid professional selves.

This thesis contributes to, not only the debates around gender and governmentality, but also the spatialisation of governmentality. The lack of attention to gender is one of the key critiques of Foucault's work advanced by feminists (see Ramazanoğlu 1993). The empirical data in this thesis as I interpret it, allows for a development of the notion of governmentality, while acknowledging its shortcomings. Governmentality in the contemporary state, as articulated by Foucault, involves understanding the deployment of expertise often in the form of professions as part of the relations of ruling. Not all professions carry the same levels of credibility within this notion of expertise and it is at this point that it becomes important to pay attention to gender. Feminised professions, such as nursing, are located within a hierarchy of expertise and the subjugated knowledges of which they are the keepers struggle for articulation, even as nurses are also agents of the state deploying expertise to 'govern' population health.

The notion of governmentality can appear as a circular trap out of which there is no escape, with rural and remote nurses caught up in its web of an almost forced self-governance of conduct within this sometimes burdensome hierarchy of expertise. But, as is evident from the empirical data, this reading of governmentality is much too narrow, simple and constraining. While not being devoid of a sense of constraint, rural nurses work with this constraint to construct positions within health care that are authorised, although that is not to say they are unchallenged.

I suggest that those who have been negative about governmentality have been so because they have conceived of it as constraining some mythical state of 'freedom'. What it is to be 'free' as a human being means many different things

depending on the context. But within professional health care work professionals, particularly doctors, are relatively 'free' in so far as they have high degrees of control over their own practice. One of the ways that nurses attempt to gain similar levels of freedom to that which doctors have, is by using geographic distance.

Where women have often been constructed as oppressed by space, to some degree these rural nurses control physical space in ways that are very difficult in urban environments. In contradistinction to nurses who work in hospitals and in primary care in urban environments, rural primary care nurses are responsible for spaces and the health needs within them. Nurses in this sense deploy space (moving to rural areas), to make space for more autonomous practice. Many of these nurses in fact have a 'clinic of one's own' for much of the time, thus rural space becomes a space of possibility in professional terms where space and professional identity are co-constitutive of different nursing ontologies.

Rural and remote nurses use geography to increase their 'freedom', while deploying governmentality to authorise their being on the boundary of the acceptable, thus governmentalising the spaces of their practice. Here profession and place are completely interdependent, rather than one being a container for the other. I argue that the ways that nurses governmentalise selves and spaces is a strategic deployment designed to protect professional identities. In a civil society there is no such freedom as the unfettered practice of any profession and I doubt there even will be, but having more or less control over one's work is as free as one gets.

### Spatialising law

One of the forms of expertise at the heart of the notion of governmentality is that of the law. But again the material practices of rural primary care nurses point to a

spatiality, a geography, and a gendering of law. Everyday practices, spaces and remote places weave together to construct geographies of law that are significantly different to those contained and relatively straightforward legalities of urban practice. The apparently secure and certain practices of what is legal unravel in rural spaces.

In a health care climate dominated by notions of medico-legal risk, boundary-crossing practice produces anxiety, particularly in other practitioners and to some degree in nurses themselves. Rural primary care nurses context of practice 'exposes' them to risk in ways that urban practice does not. Legislative frameworks, such as those covering pharmaceuticals, based on notions of the proximity assumed of health professionals in urban environments unravel in the context of rural primary care nursing. Bypassing hard and fast legalistic notions of practice, nurses utilise systems of trust with the medical practitioners that they work with to make systems work and to attempt to 'cover' themselves legally.

As a response to this uncertain legal position, nurses deploy technologies of the self in more concentrated ways than their urban counterparts might. These technologies of the self serve to render nurses' practice accountable by means of documentation, upskilling, consultation and so on, as well as at a very pragmatic level protecting their jobs, for misconduct in any form potentially threatens nurses' jobs and hence their livelihood. Rural nurses thus work strategically with governmentality, which includes negotiating other forms of governmentalised expertise such as the law, in order to protect their practice and thus their nursing identities.

Governmentality is not simply a negative and constraining force but the ground for practice in the contemporary state. Fighting against the subtle but pervasive workings of governmentality, by assuming that one can work in any way one chooses simply places the practitioner outside of the symbolic order, beyond an

understandable and containable language. Knowing the rules and working them as hard as they can, which is an imperative in rural health care spaces, signals both resistance and compliance to the relations of ruling that operate in health care in the contemporary state. Staying within the frame delineated by individual and often different notions of appropriate professional practice, even while contesting parts of it, maintains some coherence of identity. Enough coherence, that is, to avoid fragmentation beyond containment. The maintenance of some sense of a coherent identity is important because an identity that is 'out of control' is no longer appropriate to the task of rural nursing. Focusing simply on the constraining aspects of governmentality renders agency invisible.

#### The power of the abject

This thesis makes a further theoretical and empirical contribution by exploring the highly complex way that binary oppositions work in health care. Aside from the very obvious and well worn debates about the position of nursing in relation to medicine which I have suggested places nurses as body to medicine's mind, a deconstruction of this binary pushed the debate into the realm of the semiotic and hence suggests a very deep seated desire to repress that which nursing does. This awareness goes beyond simple suggestions of hierarchy to suggest a fundamental repression. The association of nursing with the abject helps explain this repression, but also raises questions about power beyond simple linear ideas of power-over. Those who contain abjection as nurses do can be argued to inspire not only disgust, but also fear.

If the semiotic always threatens the symbolic with rupture as Kristeva suggests, then those who police the boundaries (which is what containing abjection does) must be held in some degree of fear lest they fail in their task of containment.

Degrees of protection, a sort of double distancing, are offered from this always present fear of rupture by not only repressing the abject but also silencing those who contain it. This silencing does not only come from outside, by for instance allowing the voice of bioscience to take all the conceptual space in health care, but it also comes from nurses themselves.

Being mandated to deal with the abject does not mean that nurses (and others who deal with abjection) do not feel the same disgust and revulsion as those not mandated to deal with it, but nurses can only deploy a single distancing by silence. Unless that is, nurses, scientise their practice and gain the double protection offered, erroneously, by the cloak of biomedicine. I say erroneous because the abject threatens all of us all the time in the form of death in the last instance, and all the other substances of decay prior to that, we only ever achieve degrees of separation from it. Part of the distancing tactic of biomedicine lies in its faith in its ability to cure, thus cheat death, the ultimate God trick (Haraway 1997)<sup>53</sup>.

Nurses come to be silenced at least partially by their association with abjection and the care of the body, which belong to the realm of the semiotic. Nurses are thus left in the unenviable position of needing to speak the unspeakable, which is what attempting to speak that which belongs to the semiotic amounts to. Rural nurses though have an even more complex task whereby they need to both speak the unspeakable along with other nurses, but also speak their 'other' because of their border state. Rural primary care nurses thus become the keepers and negotiators of a number of boundaries and borders all of which inspire 'trouble'.

Developing a language with which to articulate embodied nursing practice that is simultaneously understandable to policy makers presents nursing with a problem,

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<sup>53</sup> I do not mean to say that all individual doctors, or all individual nurses think in these ways, but rather to say something about the tendencies of each profession.

since speaking the unspeakable is no simple matter. Care needs to be taken in assuming that constructing a new language requires a language that is radically other to what already exists in health care since radically new languages are not immediately, if ever, authorised and acceptable. Desbiens (1999) cautions against looking for an ‘outside’ or ‘elsewhere’ from which to speak. Most importantly that “ ‘elsewhere’ is not some mythic distant past or some utopian future history: it is the elsewhere of discourse here and now, the blind spots ... of its representations...” (de Lauretis 1987 cited in Desbiens 1999: 182).

The shift in focus to look within and around existing discourses, their constructions, deconstructions, blind spots and face offs, although apparently a much more modest project, is also much more likely to be effective than a project that can only look out to radically new and unimagined spaces of emancipation or freedom, although that could be a simultaneous task. But Desbiens suggests that a bridge between the here and now and the ‘beyond’ is needed. Indeed, identifying the spaces, or gaps that provide potential openings for articulating an effective discourse of nursing mirrors the task identified by de Lauretis and Desbiens. This space making exercise is slow, exhausting, modest and hopefully ultimately effective. In order to imagine radically different futures, we first need to think ‘unsettling’ thoughts about our current subjectivities and identities and create spaces for shifting ontologies.

Different ontologies: Thinking beyond binaries.

Nursing has been largely ignored by both feminist and health geographers, thus part of the contribution of this thesis is to redress that lacuna. Besides from gaining an understanding of the positioning of nursing in health and its potential role, the rural nursing role in particular materially influences discussions surrounding binary

oppositions. One of the striking things about talking to the rural nurses who participated in this thesis was the effort that most of them went to, to insist that in spite of claims that they were trying to be mini-doctors, they were rather maxi-nurses. This self-definition of maxi-nurse is interesting for a number of reasons but not least of which that it represents a refusal, a resistance, to locating medicine as the single point of reference in health around which 'other' practitioners orbit. The ways that nurses talked about their positioning in health care also gives empirical and embodied substance to discussions about binary oppositions.

Dualistic understandings have long been critiqued, discussed and deconstructed in feminist geography (Rose 1993; Massey 1994), and these debates are very productively used to advance the understanding of the embodied practice of rural nursing as a binary-spanning practice, thus adding materiality to the theoretical understandings of spatialisations. Rose (1993: 140) suggests the notion of paradoxical space which she suggests is "associated with the emergent subject of feminism", to think past binaries. Though rural nurses do not usually claim to be feminists, there are convergences with Rose's understanding of paradoxical space that help to explain the positioning of rural nursing as somehow beyond the binary. Rose (1993: 140) suggests that what she means by paradoxical space is those spaces "that would be mutually exclusive if charted on a two-dimensional map – centre and margin, inside and outside – are occupied simultaneously". The ways that nurses occupy both biomedicine and nursing, margin and centre give material form to Rose's notion of paradoxical space. But although nurses do occupy both spaces, they are more welcome in one than the other and I can't help thinking here of the simultaneous, not always comfortable inhabiting of spaces of margin and centre as articulated by black and chicana feminists (Anzaldúa 1991; Hill Collins 2000; hooks 1984).

Biomedicine is an already colonised space that rural primary care nurses occupy with difficulty. Sometimes in contemporary discussions of fluidity, flux and multiplicity the ease or lack of it with which positions come to be occupied is erased. It is important to acknowledge the tenseness with which even paradoxical space is occupied, in many ways it is a space of discomfort, which makes its occupation all the more challenging to those who occupy it, as well as to the status quo (Bondi 2004). The power of rural primary care nurses occupying paradoxical health care space resides in their refusal of the conventional exclusions (Rose 1993), by claiming an identity as both/and, not either/or, thus the very location is subversive. This position is undeniably uncomfortable at times with those who occupy either side of the binary questioning the legitimacy of this in-between position, but nurses desire it anyway.

**Practical implications for primary health care delivery: Does the rural lead or follow?**

The final research question that I was interested to explore, while being implicated in the previous discussions of the theoretical implications also has a very practical component in that the question asked looked at the potential that the model of rural nursing had to extend beyond the rural. Remembering that without an understanding of the ways that rural nurses construct flexible, comprehensive professional identities and the ways that profession and place co-construct each other, I would not be able to draw conclusions from those understandings to address the issue of moving beyond the rural.

I am not interested in arguing for the substitution of doctors with nurses, but to suggest that there is a particular contribution that an expanded role for nursing, modelled on that of rural nursing can make to primary health care. Biomedicine has

traditionally assumed the power to dictate the terms on which health care is practised. But, a particular convergence of factors (that were detailed in chapter eight) has meant that there is a moment of possibility in which alternative models have the opportunity to stake a claim. As Rose (1999: 8) says, “the activity of government is inextricably bound up with the activity of thought. It is thus both made possible by and constrained by what can be thought at any particular moment in our history”. This is a moment in history that alternatives to conventional health care delivery can be thought.

Nurses within contemporary neo-liberalism are currently in a positive bargaining position. Population health is high on the agenda of most western governments and the World Health Organisation and national governments have identified nursing as an appropriate form of expertise with which to operationalise government health care policy. With aging populations in the west and the potential for increasing health care costs as the baby boom generation age, governments have an incentive to pay attention to population health.

One of the enduring problems that nurses have encountered in the face of biomedical dominance is articulating what is different about nursing and therefore what ‘extra’ it offers. Rather than attempt to define nursing once and for all, which for those who wish to maintain the flexibility of nursing practice would be counterproductive, I argued in chapter eight that it may be more effective to make strategic use of ‘dialects’ or a form of ‘pidgin’ as they are useful to articulate nursing in certain policy contexts, just as medicine does.

In practice, as has been shown in this thesis, rigid boundaries between medicine and nursing are hard to sustain, although there are some tasks that remain firmly the province of one or the other, and over time there is more flow from medicine to nursing than from nursing to medicine. For those who work at the borders

between medicine and nursing as rural primary care nurses do, there is a need to locate the professional self in terms of this dualism in order to define personal boundaries around appropriate practice. Locating themselves firmly within a 'nursing' framework, nurses draw on discourses of holism to explain the breadth of the work that they do without having to resort to calling themselves mini-doctors. Practising in a holistic fashion serves to construct the community as a particular type of surveillance space.

Although acknowledging the extensive critique and problematic nature of health promotion initiatives as were detailed in chapter seven, setting nurses up as uniquely equipped to deliver health care with a focus on wellness and health promotion provides a strategic bargaining language with which nurses can approach policy makers. But further to this the model presented by rural primary care nursing where nurses are responsible for the broad health needs of a defined population in a proximal rather than distal way has the potential to be even more effective.

While constructing the rural as a potential space of professional opportunity for rural nurses still in some sense constructs space as a container, the ways that the rural comes to be constructed as a surveillance space within the practice of rural nursing shows one of the ways that space/place and profession are co-constitutive. The very proximity and location of the nurse within the rural community and the nurses own broad practice serve to co-construct the rural as a particular type of health care surveillance space where 'everybody watches everybody'. Nurses' personal and professional identities are governed to some extent by this 'watching', as are the 'health behaviours' of members of the community.

This constant surveillance can be very difficult for nurses to manage on both a personal and a professional level, where it can seem as if there is no escape short of

leaving the area. In some places it is simply not financially viable to provide two nurses within the same geographical area so that the alternative on-call nurse is in close proximity. In one area nurses had proposed their own solution with several people willing to take on the role of 'travelling locum'. While the idea of a travelling locum<sup>54</sup> is already used in the area to cover nurses' holiday leave, if it were extended to cover nurses' regular days off the pressure on nurses would be significantly relieved and nurses may not feel as if they had to quit their homes on their days off.

Though of course this mutual surveillance can be constructed in entirely negative ways, in light of the drive to improve population health, this space becomes a paradoxical one. On the one hand people are subject to high levels of both formal and informal surveillance, but if the presence of the nurse serves as a continuing reminder of the need for lifestyle change then lifestyle change (as was explored in chapters five and seven) may be stimulated, so potentially benefiting the patient. Of course people are more or less susceptible to such 'reminders', but in the neo-liberal state the goal in terms of health care is to have individuals increasingly responsible for their own health, particularly those illnesses whose course is potentially able to be modified by the control of lifestyle factors, such as the influence of obesity on type two diabetes.

The model presented by rural primary care nursing appears to offer decreased fragmentation of care due to the generalist nature of the work and ensure follow-up, as much as this can ever be guaranteed, due to nurses highly visible and approachable position within the community. In small areas such as those that rural nurses work, they come to know the community quite well and this local knowledge provides added context for decisions regarding health care, for instance, can you easily send someone off to hospital if they are currently caring for a disabled grandchild, as was

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<sup>54</sup> This travelling locum currently has a camper van that the nurse stays in when doing the locum.

the case in one of the areas that I visited. In thinking about translating the model of rural primary care nursing beyond the rural it is important to acknowledge the lessons evident from the pilot of the Family Health Nurse role and resist confinement of the role to a narrow sphere of professional activity.

In the face of suspicion about what those practitioners with the identity ‘nurse’ can contribute to health care, these rural primary care practitioners who inhabit and manage the boundaries should challenge conventional models of urban primary health care delivery. Does the rural lead or follow? In this case I would argue that the rural leads in stretching understandings of who and how primary health care should be delivered. That is not to say that doctors are unnecessary<sup>55</sup> and I doubt that any of the nurses who participated in this research would want to argue that. But that there is the potential to shift the way that nursing and medical roles work in primary health care, so that nurses become the first point of contact, particularly in light of the desire to increase the focus on prevention and promotion initiatives in health care and particularly in some currently underserved areas that have trouble attracting general practitioners. These areas that have trouble attracting general practitioners are often also areas of high health care need that could benefit from a broad approach to health from a practitioners or practitioners who had time to take time beyond the presenting complaint with patients. The need to take time was one of the key factors acknowledged in the development of the Family Health Nurse role, so shifting the focus off high through-put, which would appear to be counterproductive to building patient trust in order to be in a position to provide health maintenance and promotion care.

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<sup>55</sup> In fact some of the nurses said that they would like increased contact with doctors.

The rural can be seen as a space of possibility for the articulation of professional identities that are not only satisfying to the nurses who practise them as the nurses interviewed in this thesis have indicated, but also bear translation into the urban context, as is currently being trialled in Scotland. Even though there is a shortage of nurses, there is not a shortage of already trained nurses many of whom have left practice because of their disillusionment at the nature of nursing work. Identifying and promoting different models of nursing practice may just encourage nurses to look beyond the traditional ways that nurses work and for some nurses this may be all the encouragement they need to return to practice.

The desire on the part of populations for ‘more’ in terms of health care as is evident in the proliferation of so-called alternative therapies signals part of this desire for more, and a willingness to think beyond the authority of biomedicine, since many of the therapies draw on “explanatory systems that do not follow conventional biomedical explanations” (Sok et al. 2004: 401). The growing interest of geographers in the ways that ‘therapeutic landscapes’ (Gesler and Kearns 2002; Milligan et al. 2004) work also, in some cases, moves beyond traditional biomedical understandings of health to bring in cultural, social and emotional factors in health and wellbeing. If nursing is not to be lumped in by those wanting more from health care, as an adjunct to biomedicine then it is imperative that nurses claim space for care as well as cure.

Perhaps a thesis is just the place to argue overtly for ‘care’ even in spite of what I have said about the utility of this language in policy circles and health care more generally. Any civil society should be concerned with care, not only care of the self as is promoted within neo-liberalism, but care in general, care for others. It is by being cared for, not just in terms of health care, but other forms of care such as parenting, that we come to be citizens in the world.

Although I have argued for a strategic leaving out of the concept of care in order to make a space for nursing that is more likely to be credible to those who need to be convinced, the cost of recommending this is the continued invisibility of care and care work. I would not want this strategic denial to translate into nurses producing more medicalised, mechanistic health services. But then we all carry concepts within ourselves that need to be strategically deployed where they meet an appropriate audience. The semiotic is never erased, but merely simmering under the surface. I do not wish to romanticise the possibilities of a perfect, caring practice delivered by angelic nurses. But, nurses trade in a very particular form of care that claims to be holistic, empowering and for the patient. We could do worse as a society by not making space for what nursing has to offer and if nurses cannot maintain the type of caring space that they have claimed to want to provide, then the risk is that nursing will come to be more medicalised and deserve the title mini-doctor.

This thesis has shown how marginality, gender discrimination and neo-liberalism might all be resisted and/or contested by everyday nursing practices. The implications of this resistance for the future of primary health care are potentially far reaching. In a double denial the embodied practice of rural primary care nurses is hidden. So long as this practice remains hidden then it presents little challenge – but bringing it to speech as I have attempted to do, although I am not the only one, in this thesis threatens the rupture of an already shaky masculinist biomedical symbolic order.

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