

Beginning Journeys - Volume 3

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- [Introduction](#) - *Stephen Neville*
- [The Role of Student Self Assessment in a Bachelor of Nursing Degree Programme](#) - *Cynthia Stokes*
- [Humour Therapy](#) - *Stephanie Wild*
- [Diagnostic System](#) - *Sue Wilson*
- [Male Student Nurses \(Literature Review\)](#) - *Steven Skinner*
- [Advocacy: An Ethical Dilemma](#) - *Stephen Brunton*
- [Aromatherapy](#) - *Jenny Kilday*
- [An Ethico Legal Dimension in Nursing](#) - *Esther Vallance*
- [Journalling and Reflection](#) - *Rose McConchie*
- [Complementary Healing/Water Therapy](#) - *Trish Martin*
- [Case Management: The Model](#) - *Teressa Bielski*
- [Infant Massage](#) - *Mavis Jean Beynon*

Exemplars

- [What Nursing Means to Me](#) - *Joanne Lilley*
- [To the Student Nurse](#) - *Joanne Lilley*

Research Conference Reports

- [Jackie Walker](#)
- [Cynthia Stokes](#)
- [Ruth Densem](#)
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Introduction

As the professions of nursing and midwifery head towards the new millennium significant changes have occurred for both disciplines. Nursing and midwifery practice and scholarship are taking place within a context of penetrating social, political as well as intellectual change. The transfer of nursing and midwifery education from diploma to degree will, it is hoped, develop health professionals who are critical thinkers and adaptive within a competitive and dynamic health system. The almost constant reshaping of the health system has meant practitioners from both disciplines are expected to have multiple skills, be flexible, informed and above all open as well as receptive to change.

Along with the implementation of the Bachelor of Nursing and Midwifery programmes comes an expectation to publish. For those of us in education it is a requirement from the New Zealand Qualifications Authority to not only teach but to conduct research and publish findings. Historically, practitioners have left publishing to those in education. However, if practitioners and educators join together and make a commitment to publishing we can collectively be a powerful force in shaping the future of our profession. Not only will our profession benefit from being in the academic spotlight, ultimately so will the clients and communities with whom we work.

The aim of "Beginning Journeys ... A Collection of Work" is to provide a forum for any interested parties to publish a piece of scholarly work. Writing in this way is hard work and different from writing an essay for a course. When publishing for the first time by all means use an essay, particularly one you have done well in as a starting point. However, be mindful that the editorial committee may suggest rewriting in a form that resembles a journal article. By becoming an ardent reader of journal articles the contrast between an essay and an article will highlight these differences. Apart from actually sitting down and writing, reading a variety of published works is an excellent method of developing effective writing skills. Remember the secret to good writing is providing simple and effective communication in a logical and straightforward manner. So, avoid jargon and complicated sentence structure that leaves the reader confused and disinterested.

The editorial committee has developed a written and pictorial guide to publishing work for publication. We also see our role as mentors to assist people with their work so a positive outcome is reached, that is the thrill of seeing individual ideas in print! We are grateful for the work we have received as we realise how much effort goes into getting an article published. We look forward to your feedback.

Happy reading and go well!

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Beginning Journeys - Volume 3

The Role of Student Self-Assessment in a Bachelor of Nursing Degree Programme

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This article is an abridged version of a report on a study into the use of student self-assessment in an undergraduate nursing programme. The study was undertaken as part of the Master of Education course at the University of Canterbury, in 1996.

Introduction

Self-assessment is an integral part of the wide range of assessment techniques used in the Bachelor of Nursing programme. It is important that a wide variety of tools are used to assess students, and that as a Faculty there is a need to be interpreting and using these tools in the same way, if they are to be valid measures of student learning and progress within an academic course.

The purpose of this report is to disseminate the results of a pilot study into the use of student self-assessment in an undergraduate nursing degree programme.

Student Self-Assessment

All clinical courses have a self-assessment component as part of formative evaluation for the course. It occurs in all clinical courses from Year One through to Year Three, and is an important aspect of ongoing student evaluation. In these courses, self-assessment is based on criteria generated by Faculty staff. The criteria used is the same, based on and adapted from the work of Benner (1984), and Steinaker and Bell (1979). At each stage, what is assessed varies according to the level of the student.

After a predetermined time in practice, which varies between courses, the students are asked to write down how they believe as an individual, they are performing in clinical practice in relation to the performance indicators which appear on the assessment form. The student is required to address all of the criteria relevant to their level of experience, and to give examples of why they perceive their performance to be as they have indicated. Following completion of the self-assessment, discussion of the assessment takes place with the student and the clinical tutor who is responsible for that student's supervision and teaching. This process is usually repeated two or three times each semester while the students are in clinical placements.

Theoretical Background to Self-Assessment

Boud (1991, p.5) defines self-assessment as involving students in "...identifying standards and/or criteria to apply to their work and making judgements about the extent to which they have met these criteria and standards". Such assessment can be either a supplement to teacher assessment, or in some instances can replace it. Students do not merely grade or mark their own work; they are involved in determining what is "good" work and then applying those characteristics to their own work. Where students are required to "self mark", they usually do so using teacher-generated criteria, but when they self-assess they have been partly or wholly involved in determining the criteria by which the work is assessed.

In this programme, students are doing both self-marking and self-assessing. The students use teacher generated criteria as a guideline or format for their self-assessment (self-marking), but also in the course of their self-assessing, they generate ideas about how they can improve on their practice, apparent deficiencies which need to be addressed, and hopefully reinforce to themselves, those areas where they are performing well. When students do identify deficiencies or areas for improving their practice, then seek to remedy them by their own actions and tutor assistance, they are really self-assessing.

Hammond and Collins (1991) believe self-assessment is a crucial aspect of reflection and critical practice. Self-assessment is closely related to reflection, and to them, it is a structured process in which learners judge their own performance or quality/quantity of learning done. They identify the main benefits of self-assessment as: potential for redistribution of power in the evaluation process as students become more involved; learning opportunities for students which they would otherwise not be exposed to; respect for the learner in terms of recognising they know their learning process best. Students undertaking self-assessment deserve to be trusted to do a good job especially when the limitations of teacher controlled evaluation is considered.

As a learning strategy, self-assessment appears to have many benefits. Brown, Rust and Gibbs (1994) believe there are many reasons why students should be involved in assessing their own work. To these authors, the benefits are, ownership of the evaluation process and a commitment to the outcomes; a range of skills are developed which are transferable and useful lifelong; it encourages autonomous learners with abilities to recognise strengths and weakness in their work; and the process encourages deep learning by a greater commitment to understanding and applying information. Ramsden (1992) believes students can learn more by assessing themselves; they can defend their own abilities, take increasing control over the subject matter, and can reveal the extent of their own misunderstandings better than other people.

Really beneficial, so it seems; but how well does it apply to nursing education? Is self-assessment useful or relevant in learning about nursing, and does it have relevance particularly for nursing practice?

Although the application of self-assessment to nursing education has not been widely researched, there is some quite recent literature available. It appears that the benefits of self-assessment in nursing education are many. Best, Carswell and Abbott (1990); Sedlak (1992); Hawks and Hromek (1992); Arthur (1995); Abbott, Carswell, McGuire and Best (1988) all view this learning strategy positively. Learning through the process of self-assessment helps promote professional development, enhance self awareness and self esteem.

It helps develop autonomy which is an essential element of good practice, and future practice as a registered nurse. It has implications for self-direction and self-motivation. Of particular use to students, Hawks and Hromek (1992) believe that it helps them understand the objectives underlying their learning, recognise progress towards those objectives and identify strengths and weaknesses. It makes students think more carefully about the qualities THEY are striving for. With such a focus as this on student learning, it is firmly believed by some (Arthur 1995; Best et al. 1990; Abbott et al. 1988) that self-assessment should be used only for formative evaluation. It should never be the basis on which final decisions about a student's grades are made; students must be allowed the opportunity to "experiment" and make mistakes in their learning. Using self-assessment as an outcome tool is contrary to its role in learning and education.

The cooperative nature of self-assessment, between learner (student) and teacher is discussed by Hawks and Hromek (1992); Best et al. (1990) and Abbott et al. (1988). Teachers need to collaborate with students, and be facilitators and preceptors for them. They need to assist in the overall process, offering guidance and suggestions but never making decisions for the student. Students need to be taught by teachers how to self-assess effectively; they need to be mentors, and to "model" the process by being involved in the process with the student. Self-assessment is a behaviour that takes time, and has to be learnt - people cannot be expected to be able to "just do it" (Arthur, 1995).

A small amount of information is available on students' perceptions of the process and use of self-assessment. Students in the sample from the study by Sedlak (1992) identified: recognition of learning needs based on negative rather than positive experiences; self growth from challenging situations involving patients; development of communication and technical skills; awareness of increasing self-confidence and locus for motivation coming from themselves, and awareness of emotional growth. Hawks and Hromek (1992) reported comments from their student sample as: more independence (guided by teacher); increasing knowledge, skill, performance and confidence; improved self-motivation and increased decision-making from becoming more self-directed. In the study by Abbott et al. (1988), students reported on the increased level of positive communication with teachers. Participation in evaluation gave them an opportunity to speak up for themselves, and also it made them responsible for their choices and how they would "defend" or justify their actions.

Self-assessment as both a learning and teaching strategy fits well with the philosophy of this school and with the way in which the curriculum is designed. Assumptions about teaching which underlie the department's philosophy, view it as a student centred process, which is mutually stimulating and rewarding for both student and teacher. Assessment is an integral part of the learning process, which must be flexible and relevant to the practice of nursing. The learning process over the three years enhances the move by the learner from a state of external direction, to self-direction. Skills learnt and developed in Year One are built on and extended in the subsequent two. It is accepted that there will be greater emphasis on teacher direction in Year One compared to Year Three, but teaching and learning strategies employed are designed to facilitate the movement of the student towards self-direction. It is firmly believed, that students engaging in self-assessment will do much to further their own progress towards meeting these principles.

Investigating the role of student self-assessment in clinical practice it was decided to investigate tutors' perceptions of the role of student self-assessment for two reasons. The first is the importance of self-assessment as a learning strategy in the programme. Such an important and widespread activity is worthy of assessment itself, to see if in fact it is "doing" what it is hoped it will do. The second, is the number of tutors involved in the teaching of students who, in the course of professional practice, are required to self-assess. In this respect, it would be helpful to know what perceptions those tutors have of the role of self-assessment. Do they all hold the same or similar views? Do all tutors apply the same values to teaching students about self-assessment, and are their understandings the same on what is a "good" assessment?

Data Collection, Methodology and Method of Analysis

An application for approval of a research project was submitted to the Health Research Committee, Department of Nursing, Midwifery and Health Education, and approval to undertake the study was given. The informants would be nurse educators who were teaching and supervising students undertaking self-assessment in professional practice. In order to gain differing information, it was decided to involve tutors from the three years of the programme, with at least one from each year. Tutors were approached individually and invited to participate in the study. The purpose of the study was explained, and they were given the opportunity to ask questions and clarify what their role would be. Data collection would be through an individual, semi-structured interview which would be audio-taped. Four tutors agreed to participate, and a date and time for the interview, convenient to the participants, was made. The participants were asked to choose a venue for the interview.

The participants for this study were academic staff members from the Faculty of Health and Science. All were registered nurses, had at least an undergraduate university degree, and had been teaching for more than six years. They all taught in the Bachelor of Nursing programme, in both theoretical and professional practice areas. Prior to interview, the purpose of the study was again outlined to each participant, and they were asked to sign a Consent Form. Anonymity was ensured. Participants' names would not appear in any documentation other than the transcripts used only by the researcher for data analysis. The interview audio-tape was returned to each participant at the conclusion of the study.

The length of time for the interviews ranged from 30 to 55 minutes. Three specific questions were asked of each participant. These were:

- "Tell me about your perceptions of the use of student self-assessment."
- "What do you believe the benefits of self-assessment are for students?"
- "What use are students' self-assessments to you as a teacher?"

While these were the focus questions for the interview, other questions were asked which usually pertained to a comment made by the participant, or for the researcher to clarify, or explore some point further. At the conclusion of the interview, each participant was given the opportunity to add or clarify any comments made, or to contact the researcher should there be any additions or alterations they wished to make to the original discussion. The offer to contact the researcher at any time, about any aspect of the study, remained open.

Analysis of the data was very time consuming. Each tape was played twice, and notes made, usually in the form of descriptive phrases or generalised "themes". The tapes were then transcribed and further notes or comments were made. One of the transcriptions was used to assign codes to the comments, then the three other transcriptions were analysed, using the same codes. These codes were then matched with the general themes developed while listening to the tapes. By this stage, one major feature of the data had become very clear. What was being heard and read, was generally congruent with what the literature says about self-assessment, both as an educational strategy and how it applies to nursing education. A further feature too, was the congruence in the responses of the tutors. They were all saying very much the same thing about their perceptions of self-assessment and how they applied it in practice.

Findings

The findings will be discussed in terms of similarities and differences in the perceptions of the participants, using the three interview questions as a framework.

Perceptions of Self-Assessment

The four participants made comments indicating they have similar perceptions of the role of student self-assessment. These include features such as students engaging in reflection and analysis, where they become critical of their own practice; assisting the student to determine "where they are at", and enhancing the student's own perceptions of how they are functioning.

While there were many similarities noted, there were also differences in the responses. One participant believed students don't really know where they are going, because they are exposed to such a variety of learning experiences. Her understanding seems to be that students need to be closely guided in what they are to achieve.

By comparison, one teacher sees students as taking the initiative in self-assessing, while in her supervision of students, another also actively encouraged students to take the initiative for self-assessing. It is acknowledgement that there are boundaries placed on students in terms of self assessment, but also ways to encourage student initiative.

Benefits of Self-Assessment for Students

Each of the four participants were asked to describe what they perceived the benefits were, when students were in reality, required to complete the self-assessments as part of the programme. The researcher was interested in knowing what these teachers believed the students got out of the process. The responses were quite varied. The "required to do" nature of self-assessment was described by one, although it appears that students do eventually see the benefit from it. Those students were "good" at self-assessing, benefited from the chance to reflect and develop ongoing goals for learning. Developing confidence in themselves as practitioners was very evident. Apart from knowing what the competencies or criteria a student needs to know to achieve outcomes, one saw self-assessment as an important step on the pathway to critical practice. A student who self-assessed well, developed a good understanding of the level he or she was functioning at.

Use of Students' Self-Assessment to Teachers

Again there were a number of similarities in the participants' responses, but also, each individual teacher seems to have their own focus when dealing with self-assessments. One teacher used her students' self-assessments to validate both positive aspects of the student's practice and develop strategies for them as

learners when the need for development in an area was noted. The use of self assessment to set goals was a focus for another, and it seems that she too, had some very positive experiences as a teacher, as did some of her students.

One perceived her role as one of partnership in the process, linking it to Freire's work. Being able to identify students who need help with analytical skills, and being a resource person was seen as an important benefit for teachers.

Although tutors have some differing perspectives on the role of student self-assessment, I believe that, overall it appears they are attempting to achieve the same outcomes in terms of student learning. It seems that the primary difference in how they put self-assessment into practice as teachers, has more to do with the level of student they are teaching, than their own beliefs about it.

Discussion

The purpose of this study was to determine if there was commonality amongst teachers, in perceptions of the role or use of student self-assessment in the nursing programme. If there was any major difference in perceptions, would this would have any undesirable consequences for the students? It would seem there are not any significant disadvantages for the students. Despite the reasonably high number of self-assessments the students are required to complete, and the number of different teachers the students meet with in the course of their professional practice, it is pleasing to hear that in the end the students appear to develop positively from the use of self-assessment. What was of significance in this study, was the congruence between comments made by the participants, and what was derived from the literature. Although the literature section for this study was small, when referring back to the original, fuller review, these can be identified.

The cooperative nature of self-assessment was seen as important. The partnership aspects between the teacher and the learner was identified and with it the power sharing in the evaluation process. The encouraging of self-directedness for learning was emphasised, but in keeping with the role of facilitation of learning by the teacher. The skills of analysis and reflection certainly featured, as did the need to furnish students with clear guidelines on what it is that they are to assess themselves "against".

If these findings from four teachers are representative of the understanding of self-assessment and how it is implemented, then there is certainly a good understanding of the role of student self-assessment in the department.

References

- Abbott, S., Carswell, R., McGuire, M. & Best, M. (1988), Self evaluation and its relationship to clinical evaluation. *Journal of Nursing Education* 27(5): 219-224.
- Arthur, H. (1995). Student self-evaluation: How useful? How valid? *International Journal of Nursing Studies* 32(3): 271-276.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. California: Addison-Wesley.
- Best, M., Carswell, R. & Abbott, S. (1990). Self-evaluation for nursing students. *Nursing Outlook* 38(4): 172-177.
- Boud, D. (1991). *Implementing student self-assessment*. Campbelltown, New South Wales: HERDSA.
- Brown, S., Rust, C. & Gibbs, G. (1994). *Strategies for diversifying assessment in higher education*. Oxford: Oxford Brookes University.
- Hammond, M. & Collins, R. (1991). *Self-directed learning: Critical practice*. London: Kogan Page.
- Hawks, J., and Hromek, C. (1992). Nursing practicum: Empowering strategies. *Nursing Outlook* 40(5): 231-234.
- Ramsden, P. (1992). *Learning to teach in higher education*. London: Routledge.
- Sedlak, C. (1992). Use of clinical logs by beginning nursing students and faculty to identify learning needs. *Journal of Nursing Education* 31(1): 24-28.
- Steinaker, N. & Bell, R. (1979). *Experiential taxonomy*. In Kenworthy, N. and Nicklin, P. (1988) *Teaching and Assessing in Nursing Practice: An Experiential Approach*. London: Scutari Press.

Beginning Journeys - Volume 3

Humour Therapy

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Introduction

"Laughter is the best medicine."

This paper will provide an introduction to the use of humour therapy as a complimentary therapy for nurses. Following a brief introduction to the concept of holism and to humour therapy in general, the history of the treatment will be detailed. Methods of delivering therapeutic humour treatments will be explained, and two examples of humour in clinical settings are included. To conclude, some of the benefits for the client are described. It is hoped that humour therapy may be seen as a useful tool for nurses who wish to practice within an holistic nursing framework.

Holism

"The concept of wellness: that state of harmony between body, mind, emotions and spirit in an ever-changing environment." (Brouse, 1992, p.325)

In many works concentrating on holism and health, the elements in the above quote are central in defining holism. Namely, the theme of wholeness - that the health of an individual cannot be broken into separate systems and parts. In order to aid healing, health professionals need to be open to any or all of the client's body, mind, emotion or spirit that is needing attention.

Thus, practising nursing within this model of health requires recognising the uniqueness of each individual and how they perceive, and live their health. The best results for the client can then be achieved by working closely with them to enhance their health.

Humour Therapy

Humour therapy is the term given to a therapeutic process which claims beneficial effects from the use of positive emotions associated with laughter. Mallett (1995, p.73) defines it as "amusing intervention used by the health care professional or patient to produce a beneficial response in the patient". While research into the effectiveness of humour therapy is continuing, many of the potential gains from this healing tool are already being utilised. Adams (1993) outlines the rationale behind keeping a generally cheerful atmosphere circulating around health care facilities in order to lift the spirits of those seeking health care services. As primary caregivers, and those who spend a majority of time with clients, nurses are in a prime position to deliver this atmosphere, and specific humour interventions to their clients. The description of this process will be developed and expanded on throughout this paper.

Historical Background

Although the abstract idea of laughter improving health has been around for centuries, the modern therapeutic use of humour largely originated in the 1970s by an American journalist called Norman Cousins (Mallett, 1995). Cousins detailed his experiences in overcoming a serious chronic disease and the primary curative factor was documented as laughing (by stating that ten minutes of laughing gave him two hours of drug-free pain relief). This caused some controversy in the medical community and started considerable interest in the area (Adams, 1993).

In what may be looked on as a coup for proponents of the therapy, the Journal of the Royal College of General Practitioners (1985) contained an editorial which resoundingly supported the physiological basis of laughter as a therapeutic painkiller, stress reduction agent, calorie burner and aid to digestion (Hodgkinson, 1987). Since then many doctors, researchers and nurses have studied the effects of laughter on health and the resulting therapy is now known as humour therapy. It has developed beyond random acts of utilising laughter and humour sources for random clients, to somewhat of a science. Considerable evidence is mounting that indicates humour and laughing may prove to be a most radical, but effective tool for healing though continued research is needed. (Adams, 1993; Harries, 1995; Mallett, 1995).

In many ways then the sources and applications are limited only to the imagination of the nurse, or other health professional, and the client (Ditlow, 1993).

Clinical Settings

James (1995) details the use of a humour cart in an oncology ward in a US hospital. She states, based on her experiences the use of humour is extremely useful to this group of clients. It is thought that the therapeutic benefits of stress reduction and increased morale and general wellbeing are particularly beneficial.

The process for utilising this therapy is outlined. It includes making a detailed assessment of the client to find the most suitable source of humour for that particular individual. Contraindications are given, the main three being timing, receptiveness and content (James, 1995; Mallett, 1995). Humour is not appropriate in a crisis situation, and can be unsettling if used excessively on first meeting a client it must be used in an atmosphere of trust and the importance of assessing what the client likes is an ongoing process. Finally almost all of the literature concludes that "humour that is sexist, ethnic, or ridiculing should be avoided" (James, 1995, p.244).

Evaluation can be achieved by the nurse looking for a number of observations. The initial response, such as laughing or smiling, is almost a prerequisite in determining effectiveness (James, 1995). Talking with the client to assess emotional changes is also important and special note of a decrease in anxiety or stress is a key sign that the therapy is worthwhile for that client. A reduction in pain, or the use of pain medication (requested by the client) can often occur with particularly successful therapy.

In a more general clinical setting, Patch Adams (1993) argues for, and clearly outlines the process of setting up "a silly hospital" (p.65). He claims that "the most important elements of bedside manner are not medical knowledge or skill but the qualities inherent in fun and love" (p.68). Adams proposes obtaining a joint decision from management, staff, clients, and their families that accepts humour therapies and encourages a generally cheerful and happy working and healing environment. Nurses, often the largest single group of staff members in a hospital, and as people who spend the most time with clients, can be central to making this decision work.

Getting community support is also seen as important for Adams. Utilising the community's creative individuals; hiring clowns and playful people to do the 'work' of cheering patients and creating a playful environment are all possible ideas to be initiated. Finally Adams (1993, p.69-70) states:

"Few if any happy hospitals exist. Most people hate going to a hospital and have traumatic experiences when they do. Yet, it doesn't have to be this way if we make great efforts to change it.

Service to people in times of pain and suffering should - and can - bring rich fulfilment. Let us call on humour (sic) to lend a hand and make medicine fun."

Benefits to the Client

One of the primary benefits of humour therapy is that it can aid in the prevention of illness. James (1995) details the connection of illness to stress, recognising that humour and laughing are very effective at relieving stress, and in many cases a simple cheerful manner can aid in reassuring a client. Humour can also play a large role in facilitating coping with illness, including releasing feelings associated with changes in lifestyle or health.

Norman Cousins's claim of laughter as an analgesic has been partially backed by research. It is thought that laughter can release endorphins into the body. Other physiological effects have been noted including enhancement of the immune system, decreased muscle tension and better heart functioning (Mallett, 1995; Ditlow, 1993; James, 1995). The emotional effects can include less anxiety, tension and stress, while greater feelings of hopefulness and wellbeing add to an increase in morale (James, 1995).

Other therapeutic uses for humour therapy include aiding health education, continuing development of rapport, and enhancing other treatments such as speech therapy or physiotherapy programmes (Astedt-Kurki and Liukkonen, 1994).

Conclusion

Humour therapy is a new therapeutic tool that nurses can fully utilise to encourage feelings of wellness in their clients. As an extremely individual treatment it is perhaps the perfect example of client centred care and can be seen as an excellent medium for establishing an overall therapeutic relationship with a client. This is in addition to several proven physiological benefits to the client from the simple, often free act of laughing, making it an effective tool to promote general wellbeing in many different health care settings.

References

- Adams, P. (1993). *Gesundheit! : Bringing good health to you, the medical system, and society through physician service, complementary therapies, humor, and joy*. Vermont: Healing Arts
- Astedt-Kurki, P., & Liukkonen, A. (1994). Humour in nursing care. *Journal of Advanced Nursing* 20(1): 183-188.
- Brouse, S.H. (1992). Analysis of nurse theorists' definition of health for congruence with holism. *Journal of Holistic Nursing* 10(4): 324-336.
- Carlisle, D. (1990). Comic relief. *Nursing Times* 96(38): 50-51.
- Ditlow, F. (1993). The missing element in health care: Humor as a form of creativity. *Journal of Holistic Nursing* 11(1): 66-79.
- Harries, G. (1995). Use of humour in patient care. *British Journal of Nursing* 4(17): 984-986.

Hodgkinson, L. (1987). *Smile therapy: How smiling and laughter can change your life*. London: Macdonald Optima.

James, D.H. (1995). Humor: A holistic nursing intervention. *Journal of Holistic Nursing* 13(3): 239-247.

Mallett, J. (1995). Humour and laughter therapy. *Complementary Therapies in Nursing and Midwifery* 1(1): 73-76.

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Beginning Journeys - Volume 3

"Diagnostic Systems such as DSM-IV are not Applicable to 'Non-Western' Cultures"

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This paper was written as part of the assessment for the paper, The Nature, Extent and Assessment of Mental Disorders, a multidisciplinary paper examining many aspects of Mental Health and Illness. The paper is offered by the Christchurch Medical School, and is part of the Master of Health Sciences (Nursing) curriculum.

In this essay the diagnostic tool, Diagnostic and Statistical Manual of Mental Disorders Version IV (DSM-IV), will be examined as to the validity of its use in non-Western cultures. To understand the role that classification plays in contemporary western perspectives of mental health, there needs to be a brief introduction to historical influences on Western psychiatric perspectives. Further, the very theme of the essay assumes that the term culture equates to ethnicity. The term culture will also be examined to determine what possible meanings it has, and how this also impinges on the connection between culture and the use of DSM-IV in the diagnosis of psychiatric disorders.

There possibly has been an interest in the human psyche since the beginning of time, but evidence of mental disorders appears to have been recorded for the first time in Egypt dated 3000 BC. The related inscriptions describe possible senile dementia affecting Prince Ptah-hotep. Other disorders noted in both Egypt and Sumeria include melancholia and hysteria recorded in 2600 BC. Further early recordings of mental disorder classification between 1400 BC and 900 AD are found in India and Greece, and include the writings of Hippocrates, Plato, Galen and Rhazes (Mack, Foreman, Brown and Frances, 1994).

However, major influences in "modern" psychiatry and classification of mental disorders have come from the seventeenth to nineteenth centuries. In the seventeenth century Descartes formulated the dualistic mechanistic perspective of the human, that of separation of the mind (soul) and body. Descartes described emotions as having "... six passions...." that were "...free and immortal" with "...learning and experience merely provided the occasions for the manifestation of innate ideas" (Capra, 1983, p. 169). Other influences in the seventeenth century include Spinoza, who disputed Descartes' dualistic approach and described instead a spiritual view that he called monism, and Leibniz, who described "monads" as "organismic units" that had the human soul within, with no interaction between mind and body (ibid., p. 169-170).

In the eighteenth century the main influences appear to have come through the work of Sydenham, Locke and Hobbes who refuted Descartes' mechanistic views and attempted to apply a more "botanical" approach, using observation and empirical data to formulate criteria for illness (Capra, 1983; Mack et al, 1994). This along with the work of Hume, Hartley and Wundt lead to a Newtonian approach to health and illness. Wundt, being described, by Capra (1983, p. 171), as the "founder of scientific psychology," formed the first psychology laboratory using experiments to try to understand human perception and behaviour.

In the nineteenth century, with increased understanding of anatomy and physiology, there became an awareness that the mind and body were interconnected. This, however did not mean that the classification and possible cause of mental illness became any easier. Throughout the nineteenth and early twentieth century, several schools of thought were established to try to explain mental disorders. These schools in the nineteenth century included Pinel and his school of Moral Treatment, Sechenov and his work on reflexology and neurological reflex, Weber-Fechner's law of the mathematical relationship between sensations and stimuli and the orthodox experimental psychologists with their reductionist dualism principles (Capra, 1983). Other schools included holism such as Wertheimer's gestalt theories of wholeness and James' functionalism (his scientific experimental approach and the interaction and interdependence of mind and body) (Capra, 1983; Mack et al., 1994).

This time also saw a greater use of asylums and the separation of the insane from the disabled, dependant and disreputable people (Symonds, 1995). The reformists accepted state care of the insane as an inevitable response to social order, due to the Industrial Revolution. However Foucault has argued that the asylums were not a humane response, rather a way of bringing madness under the control of reason (ibid.).

In the early twentieth century the two main schools of thought were influenced by the late nineteenth century work of behaviourists and psychoanalysis. The main proponents of behaviourism include Watson, Titchner, and Wurdtt, and also the work Pavlov had done on conditioned reflexes. Watson believed in a stimuli-response mechanistic approach to human behaviour, and the importance of external stimuli to human response. Later behaviourists who followed Watson, included Hull and Skinner who examined the role of operant behaviour (Capra, 1983). Meyer also played a role in psychobiology with the integration of individual life experiences with physiological and biological data (McCrone, 1996).

The other school of thought in the early twentieth century was that of psychoanalysis, who rejected the then biomedical model of psychiatry in favour of one that looked for psychological causes of mental illness. The main proponents of this school of thought included Charcot, who was successfully using hypnotism in the

treatment of hysteria in the late nineteenth century, and Breuer and Freud. The success of hypnosis had called into question the role of an organic origin for mental disorders. However despite the reluctance of Freud to accept an organic origin for mental disorders he attempted to establish a link between Newtonian physics and psychoanalysis, especially adopting the concept of action/reaction, but changing it to drives/defenses (Capra, 1983).

At the same time that philosophical and theoretical changes were occurring in Europe and America in relation to attitudes toward mental illness, other changes were also occurring. These included legislative changes, such as the British Poor Law Amendment Act, 1834, and Lunacy Act, 1845, and the French Asylum Law of 1838, resulting in introduction of asylum care. The change to asylum care also meant that there was a captive group able to be observed, which in essence was the "modern" starting point for "official" classification of varying mental disorders (Chung and Nolan, 1994; Mack et al., 1994; Symonds, 1995).

Observation was the predominant theme of the positivistic philosophy of care of this time. Although it required people trained in scientific enquiry to carry out the observations, it was the "unskilled" nurses who recorded the observations. The doctors were able to justify this by saying it was them who analysed the data, not the nurses (Chung and Nolan, 1994).

Kraepelin wrote what is considered to be the first modern nosology (classification) of psychiatric illness. He postulated that if a group of patients had similar symptoms that followed the same path, then perhaps they had the same disease. Kraepelin hoped to find a "natural cause" for these diseases (Mack et al., 1994, p. 519).

In 1918 the American Medico-Psychological Association and the National Committee for Mental Hygiene produced a list of 22 disorders that they considered could be used universally. In the 1930's the American Medical Association published the Standard Classification. However, due to the resulting traumas of World War II it soon became obsolete. As a response to the WHO releasing the International Classification of Diseases (ICD), the United States Health Services and American Psychiatric Association produced the first Diagnostic and Statistical Manual in 1952. It was described by Raines as "flexible and inclusive" of "new and original ideas" (Mack et al., 1994, p. 519). The DSM also had a secondary role, that of providing funding to hospitals from insurance companies, for patients with "recognised" disorders.

DSM-III in 1980 became a classification scheme that allowed for research and communication over a wide field (Mack et al., 1994). Rogler (1993) criticised DSM-III-R as being inadequate in addressing the importance of cultural issues, and the relevance of culture in relation to the individual's experience of their health status. Not only this, but also the importance of whether an individual can understand the culture of a psychiatric setting, and in particular assessment.

DSM-IV was commissioned both as a response to the impending release of ICD-10, and in order to be a system "based on a thorough review of the results of empirical science" (Mack et al., 1994, p. 250). An effort was made to enhance DSM-IV internationally, and also throughout the diversity of cultural and ethnic groups in the United States. It also brought a descriptive diagnosis and medical model to psychiatry, thereby reframing the biopsychosocial model (Wilson, 1993).

The manual makes fleeting reference to cross-cultural issues. In the introduction there is a brief mention of issues "specific culture, age, and gender features" (DSM-IV, p. 9), Appendix I dedicates seven pages to an "outline for cultural formulation and glossary of cultural bound syndromes" (*ibid.*, p. 843-849; see also Wilson and Skodol, 1994). However it falls down in that in the general discussion on different disorders, cultural aspects are on the whole ignored. It is up to the people assessing and treating individuals to look at Appendix I. Appendix I also fails to recognize the term culture in the broadest sense, and focuses primarily on ethnic, and to a lesser degree spiritual aspects of the individual's identity.

Wilson and Skodol (1994) also stress the importance of looking at people from their individual, not the clinician's, cultural contexts. This is not to say however, that cross-cultural factors were ignored up until the use of DSM-IV. Kraepelin had used data from Germany and Java to formulate his hypothesis that different people with similar symptoms following a similar course, may have the same disease, and that the diversity within these symptoms may have been due to cultural factors (Stein, 1993). Twemlow (1995) comments that the problem with any diagnostic classification is that it is reductionist in nature. This could potentially lead to the illness being treated and not the person as a whole, and their cultural needs.

The issue of the recognition of cultural identity in relation to diagnosis of psychiatric disorders, appears to have become a major issue in recent years. Since the introduction of DSM-III, discussion has included that of the lack understanding and recognition of different cultural identities (see for example Alarcon, 1995; Al-Issa, 1995; Kleinman and Cohen, 1997; Lewis-Fernández and Kleinman, 1995; Levine and Gaw, 1995; Rogler, 1993; and Twemlow, 1995).

Much of the research on the lack of cultural awareness in diagnosis of psychiatric disorders has addressed issues relating to ethnic and spiritual beliefs and values. Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day and Bertelsen (1992) used ICD-9 to carry out a World Health Organisation study of people diagnosed with severe mental disorders in 12 different countries. They were able to diagnose a disorder using one overt psychotic symptom. Havenaar, Rumyantzeva, Filipenko, van den Brink, Poelijoe, van den Bout and Romasenko (1995) looked at the use of alcohol in the Russian Federation and Belarus. They found that due to attitudes toward alcohol in Europe in general and in the Russian Federation and the Belarus, it was difficult to place a western definition of what constituted "symptoms that are in excess of a normal and

expectable reaction to the stressor" (p. 423).

Al-Issa (1995) looked at the symptom of hallucination, a symptom that in a Western perspective could be considered a sign of a major psychological or physical disorder requiring treatment. Often it is seen as a symptom of a psychosis and/or schizophrenia. Al-Issa (p. 369-370) discusses that "rational cultures" tend to have rigid negative thoughts toward hallucinations, such as schizophrenia, whereas "less rational cultures" tend to see hallucinations as a positively valued experience often associated with spirits and trance-like states that connect between spirits and the individual.

While much of the debate has had an anthropological aspect, therefore primarily addressing ethnic differences, culture encompasses more than ethnicity. Ritchie (1992) describes culture as having many meanings, some visible and some invisible. These include beliefs and values; the way of life an individual and group undertakes; common languages (this includes not just major languages such as English, German, Samoan, but also local dialects and group slang); spirituality and other things that can enable a person to feel they have a common identity with others. Lewis-Fernandez and Kleinman (1995) look at culture from a cross cultural perspective. They describe it as a "bottomup" process and that it has a moral basis (p. 434). Fernandez and Kleinman also include gender, age, social status and social role as important components of a cultural identity.

For this writer the term culture also has many meanings. Culture is the whole way of life of an individual and the group/groups they belong to. This includes such things as forms of communication, decision making, ideology, what is considered important, and the structure of the group. It is what signals how the individual members of a group can identify themselves, and can happen on a conscious and unconscious level. Culture can be identified not only from an ethnic perspective, but also age, gender, spiritual identity, sexual orientation and groups we belong to (such as health professionals, students, scouts, members of a sports team).

Taking this into account, and when looking at the use of the DSM-IV from a cultural perspective, should we just be examining it from an ethnic perspective? While it may be easier to research the role of a diagnostic tool from an ethnic perspective, and much valuable work has been done in this area, each individual being assessed comes with much more than just an ethnic identity. An example of this is given by Twemlow (1995) who mentions an assessment carried out on a young black American woman, who had used the word "evil". The person assessing her assumed that this indicated splitting and/or a psychotic process was taking place but in fact, what the woman had meant when using the word evil, was bad.

In order for DSM-IV, or ICD-10 and any other diagnostic tool to be considered a useful tool in diagnosis of mental disorders, not only in Non-Western cultures but all cultures, it needs to be a reliable and valid tool. While it could be argued that these diagnostic tools are reliable, in that you can take a set of symptoms, and assess an individual anywhere in the world, and come up with a diagnosis, if it is taken out of that individual's cultural context is it a valid diagnosis? As shown earlier in the study by Al-Issa (1995) in looking at the meaning of hallucinations. Weiss, Ragman and Channabavanna, (1995) also questions the validity and stability of diagnostic criteria. They argue that validity is dependant on assumptions, which could be misleading and stability varies across cultures. This writer would argue that in their present state these diagnostic tools are neither reliable nor valid in a cultural context.

Kleinman and Cohen (1997) show that in a WHO study, on average a doctor fails to diagnose mental health disorders more than half the time. They argue that in order for psychiatry to become a hard science and raise its status that the "medical disciplines... have narrowly focused the biological underpinnings" while at the same time opting to "discount" culture and socio-economic factors (p. 77). Kleinman and Cohen also reinforce the argument that mental illness is "experienced in the cultural and social contexts that make symptoms and outcomes different" (p. 77). Stein (1993) adds a valuable argument as to whether future DSM editions should separate culture and diagnosis. Stein argues that it is "paradoxical that both diagnosis and culture were on separate axes, as diagnosis is constructed within a particular culture" (p. 326).

This essay has looked at the historical influences on Western attitudes toward mental illness and the eventual move toward formal diagnostic tools and treatment of those perceived mentally ill. It has also examined issues relating to culture, including the apparent lack of importance placed on culture in the broadest context by DSM-IV, and other diagnostic tools. Finally the essay looked at the issue of culture and what the term means beyond the implied definition of ethnicity. It is contended that DSM-IV and other diagnostic tools are not reliable, or valid tool to use in Non-Western cultures, and arguably within any cultural context.

Bibliography

- Alarcon, R. D. (1995). Culture and psychiatric diagnosis: Impact on DSM-IV and ICD-10 In: Cultural psychiatry *The Psychiatric Clinics of North America* 18(3): 449-466.
- Al-Issa, I. (1995). The illusion of reality or the reality of illusion: Hallucinations and culture. *British Journal of Psychiatry* 166: 368-373.
- American Psychiatric Association (1994). *DSM-IV: Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Capra, F. (1983). *The turning point: Science, society and the rising culture*. London: Harper Collins.

- Chung, M. C. & Nolan, P. (1994). The influence of positivistic thought on 19th century asylum nursing *Journal of Advanced Nursing* 19: 226-232.
- Havenaar, J. M., Romyantzeva, G. M., Filipenko, V. V., van den Brink, W., Poelijoe, N. W., van den Bout, J. & Romasenko, L. (1995). Experiences with a checklist for DSM-III-R in the Russian Federation and Belarus. *Acta Psychiatrica Scandinavia* 92: 419-424.
- Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., Day, R. & Bertelsen, A. (1992). Schizophrenia: Manifestations, incidence and course in different cultures. A World Health Organisation ten-country study *Psychological Medicine Monograph Supplement* 20.
- Klein, D. F. (1995). What's new in DSM-IV. *Psychiatric Annals* 25(8): 461-474.
- Kleinman, A. & Cohen, A. (1997). Psychiatry's global challenge *Scientific American*, March, 86-89.
- Lewis-Fernández, R. & Kleinman, A. (1995). Cultural Psychiatry: Theoretical, clinical and research issues in Cultural psychiatry *The Psychiatric Clinics of North America* 18(3): 433-448.
- Levine, R. E & Gaw, A. C. (1995). Culture-bound syndromes in Cultural psychiatry *The Psychiatric Clinics of North America* 18(3): 523-536
- McCrone, S. H. (1996). The impact of the evolution of biological psychiatry on psychiatric nursing *Journal of Psychosocial Nursing* 34(11): 38-46.
- Mack, A. H., Foreman, L., Brown, R. & Frances, A. (1994). A brief history of psychiatric classification *Psychiatric Clinics of North America* 17(3): 515-523.
- Ritchie, J. (1992). *Becoming bicultural*. Wellington, New Zealand: Huia Publishers
- Rogler, L. H. (1993). Culture in psychiatric diagnosis: An issue of scientific accuracy. *Psychiatry* 56: 324-327.
- Stein, D. J. (1993). Cross-cultural psychiatry and the DSM-IV. *Comprehensive Psychiatry*, 34(5): 322-329.
- Symonds, B. (1995). The origins of insane asylums in England during the 19th century: A brief sociological review. *Journal of Advanced Nursing* 22: 94-100.
- Twemlow, S. W. (1995). DSM-IV from a cross-cultural perspective. *Psychiatric Annals* 25(1): 46-52.
- Weiss, M. G., Ragman, R. & Channabavanna, S. M. (1995). Cultural dimensions of psychiatric diagnosis: A comparison of DSM-III-R and illness explanatory models in South India. *British Journal of Psychiatry* 166: 353-359
- Wilson, H. S. & Skodol, A. (1994). Special Report: DSM-IV: Overview and examination of major changes. *Archives of Psychiatric Nursing* 8(6): 340-347.
- Wilson, M. (1993) DSM-III and the transformation of American psychiatry: A history. *American Journal of Psychiatry* 150(3): 399-410.

Beginning Journeys - Volume 3

Male Student Nurses: What is the Uniqueness of their Educational Experience?

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Introduction

The purpose of the following paper is to present a literature review of five articles which relate to the experiences of being a male student nurse. Immediately following this introduction a research problem will be defined which will provide direction for the discussion of the literature. A broad outline of the topic area will be given, which will incorporate my personal reasons for choosing this topic and the potential benefits to nursing that research into this area can provide. The literature review will reveal that research into this area has been limited and until recently, narrow in scope.

Research Question: Male student nurses: What is the uniqueness of their educational experience?

Background

Males are under represented in the nursing profession. They comprise only 3% to 5% of all nurses (Kelly, Shoemaker, & Steele, 1996). In ancient civilisation and in the Crusades if an injured or sick person needed a nurse a man most likely would have answered the call. It was not until the Nightingale era that nursing became feminised. The nursing role has consequently evolved under this feminine influence and this contributes to the perception of nursing as a female occupation. This perception of nursing has resulted in negative attitudes and stereotypical behaviour towards male nurses.

This area is of particular interest to me because as a male entering this profession I have experienced certain barriers to participation, and believe that many of my experiences differ from those of my female colleagues. I believe that the differences between the cultures of male and female are overlooked by learning institutions and this can cause distress to male students. This view is supported by research findings which have identified that there are differences between male and female forms of caring and the male form is often overlooked (Patterson et al, 1996). This research has also identified that many male students are reluctant to talk with their tutors regarding aspects of their masculinity as they believe that the tutors (being woman) would not understand the difficulties they face. Research into the differences of perception between male and female nursing students may help understand these differences.

Potential Benefits to Nursing

Schoenmaker and Radosevich (1976, as cited in Kelly et al., 1996) have made an assumption that "male nurses would bring a different approach to solving the problems of health care" (p.170). Although the number of males entering the profession is increasing, males still only constitute a very small percentage of the total number of nurses. Research undertaken to identify the experiences of male students may help learning institutions understand how to attract more males to the profession.

Literature Review

An examination of the literature has indicated that research regarding male nursing students is insufficient, and until recently has focused mainly on four predominating themes. These are demographic and personality characteristics, men in obstetrical nursing and role strain in male nursing students (Okraïnec 1994; Patterson et al., (1996). This research has been criticised for using small samples, having limited scope and inconsistent findings (Streubert, 1994; Okraïnec, 1994). More recent studies have begun to focus on the lived experiences of male student nurses with a purpose to gain insight into male students' perceptions of nursing, their education and the uniqueness of the male students experience (Kelly et al., 1996; Streubert, 1994; Patterson et al., 1996; Okraïnec, 1994). The following themes have emerged from these studies:

Role Strain

Controversy remains concerning the role strain present. Role strain is said to occur when an individual, because of his or her position "participates in a multitude of role relationships with a variety of other individuals, which results in dichotomous demands or expectations from these various roles" (Sherrod, 1991, p. 495).

Sherrod (1991) found that within the obstetric area males indicated significantly greater role strain than females. However Okraïnec (1994) found little evidence of role strain for males. Although the findings of Okraïnecs' study did indicate that there was a problem within the obstetrical area for males, virtually none of the males surveyed indicated that they would select obstetrics as a potential career. This difficulty in the obstetrical area has also been identified in research by Streubert (1994). Another research study has indicated that the conflict experienced when learning to be a nurse is not due to role strain but may relate to the way persons of either gender have been socialised (Patterson et al., 1996).

Sex Role Stereotypes

There is a strong perception that nursing is a female occupation and this stereotyping exists even among nursing students. This is evident in the results of a study conducted by Okrainec (1994). One third of respondents in this study indicated that women were superior in their natural aptitude for nursing and over half believed women to be superior to men in expressing their feelings. A slightly different suggestion to this has been made by Patterson et al. (1996) whose research findings suggest that males, due to their socialisation, express caring in an equally successful but different manner to that of females, and that this form of caring is not always recognised in the profession.

This is supported by findings of other studies which have identified that the image of nursing as a feminine occupation creates feelings of isolation, exclusion, fear of being perceived as unmanly, anxiety about clients acceptance of male students, and perceptions of being treated differently (Kelly et al., 1996). Patterson et al. (1996) identified that many male students feel that to succeed they will have to suppress their conventional masculine behaviours. Both Kelly et al. (1996) and Patterson et al. (1996) identified that there is a lack of male role models for students to identify with. They felt that more male role models would diminish the difficulty of being in a female dominated profession.

Barriers to Nursing

Significant barriers to men in nursing education have been identified by several researchers. These include the interpretation of caring as women's work, lack of information from school counsellors, change of roles within families (Kelly et al., 1996). Patterson et al. (1996) identified that the separate realities that exist between male students and their female tutors, colleagues and nurses, results in tutors', peers' and nurses' expectations that the male students should care for patients the same way as a woman would do, without recognising the differences that gender imposes.

Areas for Further Research

Streubert (1994) and Okrainec (1994) conclude from their literature review that most researchers have assumed that the experiences of male students are the same as females. They indicate that there is a need to investigate the lived experiences of being different and the effects of being a minority within the profession. This is needed to create an awareness in educational programs of the unique needs of male students, and to enhance the quality of their education.

Additional research to explore the nature of male caring within the profession and to compare the lived experiences of males and females as they learn to care is needed to help understand the differences encountered.

Conclusion

Until recently research into male student nurses has been limited and narrow in scope. Themes stemming from the more recent research into the area of male student nurses relate to role strain, stereotyped roles and barriers to men in nursing education. There is still debate over the presence of role strain in male students and if it is any different for females.

Nursing is still looked upon as a woman's occupation. This poses problems of perceived loss of masculinity, isolation and exclusion within the learning institution, and a perception of being treated differently. Stereotyping of roles also leads to many of the barriers faced by males entering the nursing profession.

The barriers which have been identified are a lack of information from school counsellors, change of roles within families, the separate realities that exist between male students and their female tutors, colleagues and nurses, which results in a lack of understanding of the unique needs of male students. Further research which compares the lived experiences of male students to females may increase the knowledge of these unique needs and help educators to enhance male student nurses education.

References

- Kelly, N. R., Shoemaker, M., & Steele, T. (1996). The experience of being a male student nurse. *Journal of Nursing Education* 35 (4): 170-174.
- Okrainec, G. D. (1994). Perceptions of nursing education held by male nursing students. *Western Journal of Nursing Research* 16(1): 94-107.
- Patterson, B. L., Tschikota, S., Crawford, M., Saydak, M., Venkatesh, P. & Aronowitz, T. (1996). Learning to care: Gender issues for male nursing students. *Canadian Journal of Nursing Research* 28(1): 25-39.
- Sherrod, R. A., (1991). Obstetrical role strain for male nursing students. *Western Journal of Nursing Research* 13(1): 494-502.
- Streubert, H. J. (1994). Male nursing students perceptions of clinical experiences. *Nurse Educator* 19(5): 28-32.

Beginning Journeys - Volume 3

Advocacy: An Ethical Dilemma

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The concept of advocacy has become integrated into the professional codes of conduct for nurses in most countries over the last decade or more. However a united definition of advocacy has not surfaced explicitly nor has one single system of operationalisation. As nurses, not only are we uncertain of the meaning of the concept and its application in practice, we often follow blindly the desire to be an advocate for our clients without questioning the ethical dilemmas that being an advocate might create.

In an effort to determine an ethical position on advocacy I would like to move through four stages of argument as suggested by Johnstone (1995). Firstly, I will formulate a definition of just what it is to be a patient's advocate, and secondly, I will discuss whether there is a need for such an advocate in a health care context. I will then examine the hypothesis that nurses are in a unique position and best suited to act as patient advocates, and lastly I will clarify the conditions and circumstances under which nurses acting as patient advocates ought to fulfil their role.

Advocacy is most easily defined by examining what it is that nurses are doing when they are acting as advocates. Evans (1992) suggests that socially and historically advocacy has been about the selfless championing of the less privileged and vulnerable in society. Kohnste (1982, cited in Evans, 1992, p.380) describes advocacy as the act of "informing and supporting a patient ... the act of loving and caring", and for Curtin (1979, cited in Evans, 1992, p.380) advocacy "exemplified an ethic of caring based on the shared humanity of the nurse and patient". Gadov 1983 (cited in Johnstone, 1995) in her concept of existential advocacy defines the role of the advocate as the effort to help persons become clear about what they want to do by helping them discern and clarify their values in a situation (p.278).

The Concise Oxford Dictionary defines an advocate as "one who pleads or intercedes on behalf of another". This can be extended to patient advocacy which can be defined as informing clients of their rights in a given situation, making sure that they have all the information necessary to make an informed choice, supporting them in their decision and protecting their interests (Sawyer, 1988). The motivation for these acts coming from nurses' desire to care for their patients.

In New Zealand advocacy is probably best defined in terms of the Treaty of Waitangi; protection, partnership and participation (NZNO, 1993) include advocacy in two out of five standards. Standard two states that "within their scope of practice, nurses are responsible for the safety and wellbeing of their clients" (p.10), the outcome for this standard includes patient advocacy. Standard three broadens the scope of this advocacy stating "nurses are responsible for entering into and maintaining a partnership with their clients, community, colleagues and employers" (p.11). It is here that controversy may come to the activities of the nurse advocate.

Evans (1992, p.384) sums up advocacy best when she describes the qualities of the nurse advocate as "reassurer, supporter, adviser, consultant, counsellor, therapist, health care humanist, contracted clinician, empowerer, health educator, mediator, confidante, information provider, intermediary, watchdog, political activist, agent of change and overseer of quality health care".

Being an advocate then is indeed a multi talented role, but is it a necessary one? Do our clients really need advocating for? Every nurse can probably bring to mind many situations wherein their client's best interests were not maintained within the health care system. On this individual level then the answer must surely be yes, our clients need advocacy to help them negotiate the intricacies of health care delivery in order for them to be able to make autonomous decisions about the care they receive.

On a societal level, however, Porter (1988) questions whether society will allow autonomy and responsibility to be given to the sick. The medical profession has always held jurisdiction over the label of illness, labelling the sickness, deciding the treatment and how the sick person should act. Health professionals are a tool of social control says Porter and this role is not compatible with that of patient advocate. Porter suggests that the closest we can come to advocacy is a form of benign paternalism although he cautions that it will be difficult to achieve benignity if we are not aware of the society in which we operate.

The client's role in this dilemma now become significant. By empowering our clients and moving them away from the traditional sick role, which research has shown can hamper recovery, we are changing or at least trying to change the way that society views illness. What then of our client's autonomous right to assume the sick role if they so choose? Should this ethic be breached by nurses forcing their advocacy on their clients? Can nurses accept and support the decisions of their clients even if the decision should reject their care? These questions lead well to the next point of contention, are nurses best suited to act as patient advocates?

Curtin (1986, cited in Johnstone, 1995) argues that the purpose of nursing is the welfare of other human beings. She suggests that the moral nature of nursing is derived from the involvement of nurses with other

human beings, the actual relationship and the promotion of that relationship and what is mutually seen as good, in this case health. Curtin terms this "human advocacy" (p.276) which she suggests is the very foundation of the nurse patient relationship. She argues that nurses are uniquely qualified as human advocates because nurses attend patients for sustained periods of time and provide patients with intimate details of physical and emotional care. This thesis though is questionable in that no single nurse would spend a total twenty four hour period with a patient and even within a shift will generally care for more than one patient. It is doubtful whether a nurse is in any better position timewise than anybody else to assume the role of advocate although in terms of intimacy the nurse is surely closest to the patient.

Gadow (1983, cited in Johnstone, 1995) too claims that advocacy is the philosophical foundation of nursing and that it determines the actual form of the nurse patient relationship. She states that nurse advocates should ensure their clients "authentically exercise their freedom to self determination" (p.278). In this sense Gadow places the ethical principle of autonomy as primary without considering other situations which may impact on the individual's ability to make autonomous decisions that are in their best interests and/or will not impact on the right to autonomy of others. Another criticism of Gadow's concept is that nurses may, in the process of helping patients "to become clear about what they want to do, by helping them discern and clarify their values in the situation" (p.278), inadvertently exert manipulation or coercion and influence the patient's choice. The question might also be raised, is it necessarily ethically wrong to manipulate benevolently another's choice if that person would do harm to themselves. It would appear then that Gadow's assertion may produce an ethical minefield in practice in that nurses have more ethical responsibilities than just the preservation of their client's autonomy.

The NZNO Standards for Nursing Practice (1993) state that nurses must work in partnership with not only their clients and their families but also with the community, colleagues and employers. In these situations the expedience of utilitarianism, the good of the many outweighing the good of the one, might produce a relationship other than that of advocacy between a client and nurse.

The judiciary in both Australia and New Zealand have expressed scepticism over the role of the nurse as patient advocate. In New Zealand at the end of the cervical cancer inquiry although the commissioner stated that "nurses most appropriately should be the advocate for the patient" (Johnstone 1995, p.273). Bickley (1988, cited in Evans, 1992, p.380) reported that Judge Cartwright expressed "reservations about the ability of nurses to stand up for patients" and therefore could not be relied upon to be effective advocates for their patients.

In the more litigious environment of America nurses must be careful not to interfere in the sacred and legislated physician patient relationship. Carnerie (1987 cited in Evans, 1992) offers some salient advice to nurses following several court cases in America and Canada. She urges nurses to be sure of their moral, professional and legal ground when defending a patient's rights "otherwise a lawyer may end up defending you" (p.380).

Porter (1988) also questions the ability of nurses to be patient advocates because they have vested interests as professionals and therefore may not challenge the vested interests of other professionals, their colleagues.

Should nurses then have a monopoly on the role of advocacy? It may be that there are others who are better suited to the job. The significant others of a client will usually be in a better position to know the intimate details of a client and their wishes with regard to health care choices but may not have the skills to negotiate within the health care system. Independent advocacy services will not face the dilemma of responsibility to colleague and employer.

A further problem is posed by cultural differences. Not only may nurses be unable to assist culturally different clients to exercise an autonomous choice, but they may set about it in a culturally inappropriate and thus harmful way. The nurse may have feelings of genuine concern and caring for the client but these are not necessarily reliable guides towards ensuring the cultural appropriateness of professional behaviour (Kanitsaki, 1993, cited in Johnstone, 1995). Hence one of the reasons for the introduction of and the emphasis on cultural safety in New Zealand nursing curricula.

No other group, however, has more contact with clients and their families in health care setting than nurses. Therefore nurses most often have the most familiarity with clients' and families' choices and are in a good position to protect those interests in a serious situation.

How then can nurses function as patient advocates in an ethical way? Should client autonomy be the prime concern of the nurse advocate even if that autonomy may do no good or cause harm to that client? It is possible to uphold the principle of autonomy until ...?

Through their research in a mental health setting Lutzen and Nordin (1994) saw emerge a concept of modified autonomy, which they defined as adjusting the meaning of self choice to suit the perceived needs of the client when there is a conflict. In practice this would entail enhancing as well as limiting the client's self choice. This definition is understood as distinct from coercion, that is, threatening the client with undesirable consequences. The obligation of nurses has been understood traditionally in terms of a professional adherence to the principle of beneficence as well as to the principle of autonomy. Beneficence provides justification for actions which decrease the client's autonomy. Lutzin and Nordin suggest that the ability to weigh the principle of self choice against the principle of beneficence by seeing, feeling and understanding the needs and wishes of the person being cared for should be viewed as a fundamental moral

responsibility in health care ethics.

Johnstone (1994, p.2651) states "that from the very moment nurses undertake to care for a patient, they are morally ... bound to ensure that no undue harm comes to the patient and that the patient's 'best interests' are maximised". It is these two ethical principles, beneficence and non-maleficence, that are paramount in the field of advocacy.

Gadow (1980 cited in Hein and Nicholson, 1994) differentiated between advocacy and paternalism thus. Individuals who have a consumerism perspective of the role see nurses as consumer guides who provide necessary information and then withdraw whereas those who have a paternalistic perspective of advocacy depict nurses as using coercion to provide a good that beneficiaries may not want violating the right to self determination. In contrast to these two perspectives, Gadow defined existential advocacy as "a nurse participating with a patient to determine the unique meaning the experience of health .. and illness is to have for the individual" (p.154). But is this advocacy or just good, responsible nursing practice?

Does advocacy have the power to achieve what it has been designed and promoted to achieve, that is, to assist patients in exercising their self determined choices? Is advocacy adequate to deal with the many other moral problems and issues that arise within the health care system? One solution is to look at advocacy as a moral theory and not just as a separate concept in its own right (Johnstone 1995).

If questions pertaining to advocacy can only be answered using the concepts and language of ethics and critically reflective moral principles then maybe it is not advocacy that defines the nurse patient relationship, as Curtin (1986, cited in Johnstone, 1995) and Gadow (1983, cited in Johnstone, 1995) suggest, but a critically reflective ethic. Perhaps the real truth is that advocacy is just a means to an end and not an end in itself. The search for an ethical position on advocacy is a search in vain because patient advocacy is the practical application of ethics within the health care system. No one group has a monopoly on ethical behaviour, certainly one would hope that all health professionals would behave ethically.

In nursing terms then we should seek not to find a way of operationalising advocacy but instead see advocacy as a way of operationalising an ethic of care incorporating the concepts of compassion, competence, confidence, conscience and commitment (Roach, cited in Tschudin, 1992). When the activities we do when we are advocating for our clients uphold these principles in practice then and only then can we be said to be advocating ethically.

References

- Evans, P. (1992). Advocacy: A role for nurses? In Gray, G. and Pratt, P. Issues in Australian nursing 3, (pp. 3737-395). Melbourne: Churchill Livingstone.
- Hein, E.C. & Nicholson, M.J. (1994). Contemporary leadership behaviour: Selected readings. (4th ed.). Philadelphia: J.B. Lippincott & Co.
- Johnstone, M.J. (1994). Nursing and the injustices of the law. Sydney: Harcourt Brace and Company.
- Johnstone, M.J. (1995). Bioethics: A nursing perspective. (2nd ed.). Sydney: W.B. Saunders/Balliere Tindall.
- Lutzin, K. and Nordin, C. (1994). Modifying autonomy: A concept grounded in nurses' experience of moral decision making in psychiatric practice. Journal of Medical Ethics 20: 101-107.
- New Zealand Nurses Organisation. (1993). Standards for nursing practice. Wellington: NZNO.
- Porter, S. (1988). Siding with the system. Nursing Times 85(41): 30-31.
- Sawyer, J. (1988). Patient advocacy: On behalf of the patient. Nursing Times 85(41): 27-30.
- The Concise Oxford Dictionary of Current English. (6th ed.). (1976). Oxford: Oxford University Press.
- Tschudin, V. (1992). Ethics in nursing. Oxford, Boston: Butterworth-Heinemann.

Beginning Journeys - Volume 3

Aromatherapy Mother Earth's Oils

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Introduction

Natural healing recognises that the human body is superbly equipped to resist disease and heal injuries. But when disease does take hold, or an injury occurs, the first instinct is to see what might be done to strengthen the body's natural resistance and healing agents.

The Greek physician Hippocrates, still recognised today as 'The Father' of modern medicine, was an advocate of essential oils as a way of stimulating the body's own healing mechanisms (White and Day, 1992).

More and more people these days are looking to natural therapies as an alternative to conventional medicine which can often have harmful side-effects. Aromatherapy is a natural therapy and a form of complementary medicine.

This paper will define the concept of holism and how holism is effective in the field of complementary healing and nursing; aromatherapy - what it is, where it came from and how it is used as a complementary healing will be discussed.

To help explain the use of aromatherapy in complementary healing, examples in clinical settings will be used, research material referred to and personal communications from qualified persons given. Finally the benefits of complementary therapy for the client will be discussed.

Holism

'Holism' or 'holistic', which means 'whole', has become a very important factor in the nursing field and health in general. Holism emphasises the 'whole' person. Instead of focusing only on the malfunctioning part, it explores the broader dimensions of the person's life such as physical, emotional, spiritual, environmental and nutritional.

Discussing a person's approach to life holistically can assist them to upgrade their health, performance and wellbeing. It is healing for the whole person and today holism is assuming phenomenal popularity and importance. By learning to gauge our own innate energy, potential weaknesses and strengths, we can all benefit from this approach (Blattner, 1981).

Holistic nursing is the conscious application of the life processes of self responsibility, caring, human development, stress, communication and teaching/learning through preventive, nurturative, and generative nursing activities to help clients help themselves toward high-level wellness (Blattner, 1981).

A Brief History: Where did aromatherapy come from?

Aromatics have been used by many civilisations throughout the world for centuries. It was a natural instinct for ancient cultures to look to nature to cure many of their physical and emotional complaints.

No one can say for sure whether the extraction and use of aromatic plants actually began in Egypt or India. It is known, that in both these countries, an important part of their culture, many thousands of years ago, involved the use of aromatic plants (Kaiser, 1995).

The Egyptians were one of the first to discover their effects. They were burning gums and resins, such as Frankincense, to clear the mind or for rituals and healing and using oils such as Myrrh and Cedarwood for embalming. In India, plants and aromatic essences were widely used for medicinal and religious purposes.

Greeks and Romans were also known to use plants, but more as perfumes and spices. The Romans favoured baths and used many oils in their daily bathing rituals and in massage (Kaiser, 1995).

In 17th Century England, aromatics were used extensively. They were the best known antiseptics at the time and were used as fumigations to destroy the "aura and poison" believed to be in the air from the plague. They burnt fires of pine in the streets and wore pomanders made of orange and cloves to ward off the Black Death (Kaiser, 1995).

During the 19th and 20th centuries came the development of chemistry and the creation of synthetic drugs. It was thought that it was better to isolate the active therapeutic properties from plants. This led to widespread use of isolated extracts and synthetics and overshadowed the use of more traditional remedies (Kaiser, 1995).

The Birth of Modern Aromatherapy

Renee-Maurice Gattefosse, a French chemist, founded early in this century, an essential oil house that produced oils for use in cosmetics and fragrances. Gattefosse accidentally discovered the amazing health power of lavender and embarked on researching the therapeutic effects of essential oils. Dr Jean Valnet, another French chemist also did a lot of research after using essential oils with great success during the Second World War. Both the work of Renee Gattefosse and Dr Valnet helped to scientifically validate 'aromatherapy' (Jackson 1987).

What is aromatherapy?

Aromatherapy is the use of natural plant essences (essential oils) which have been extracted from aromatic plants.

Aromatherapy simply means "a therapy using aromas". The aromas come from the plant kingdom - flowers, trees, bushes and herbs (Jackson 1987). The essences are extracted from a wide variety of plants and are very concentrated. For example, it takes the petals from about 30 specially cultivated roses to produce one drop of rose essential oil and several kilos of lavender to produce one small bottle of lavender essential oil.

Each essential oil has its own unique healing properties and fragrance and one essential oil may contain over one hundred different chemical constituents. The plant essences are chosen according to their specific benefits (either emotional or physical) and are used in a variety of ways to promote health and vitality, encourage healing or relaxation, relieve stress or pick us up if we feel down (Kaiser, 1995).

Aromatherapy offers people an alternative pharmaceutical medication. It can also be used to complement and enhance the effect of other forms of treatment. Home use of aromatherapy provides a holistic approach to health by encouraging people to help themselves and take responsibility for creating their own health in a practical, easy and enjoyable way (Kaiser, 1995).

Though we now tend to take a sceptical view of the power of plants, reaching instead for less subtle, quicker-acting chemical prescriptions, scientific analysis has shown that natural, time-honoured herbal medicines can be remarkably effective (Jackson, 1987).

How Aromatherapy Works

The aromatherapy way to health and beauty includes three interrelated practices (1) massage with essential oils; (2) baths, inhalants and steaming; and (3) the use of herbs in cooking and infusions or in teas (Jackson, 1987). See Appendix A: 'Description of Aromatherapy from Personal Experience'

Massage

Aromatherapy combines the nurturing and relaxing powers of touch with another powerful sense - the sense of smell. In aromatherapy massage, essential oils are applied to the skin and worked into the body using neuromuscular techniques that focus the nervous system and the invisible channels of energy (meridians). The massage loosens the tight muscles and blocked tissues, focusing on central points in the energy system. As the skin responds to the massage, its nerve endings communicate with the internal glands and organs either stimulating or calming, depending on the oils used and on the needs of the individual being massaged (Jackson, 1987).

Baths, Inhalants and Steaming

The aromatherapy bath, an important adjunct to the massage, reinforces the basic rejuvenating benefits. Essential oils added to water, stimulate the skin, relax and energise the person. Inhalants can clean congested sinuses and chests. Facial steaming deep cleanses and moistens the face with penetrating vapours (Jackson, 1987).

Teas and Herbs

The use of herbs in teas and cuisine, is a safe and effective way to augment the benefits of a healthy diet. Aromatherapists value herbs not merely to enhance flavour, but to improve good health. Fresh and dried herbs can help detoxify some foods and aid in the digestion of other foods. Some teas can work wonders for the brain, and improve organ functions (Jackson, 1987).

Essential Essences

There are several hundred essential oils produced today, each with its own history, properties and specific treatment it is used for. Some basic oils used today that are relatively easy to obtain and have proved their worth for thousands of years are: Lavender (calming and soothing); Peppermint (invigorating and refreshing); Rosemary (activates willpower and clear thinking); Sandalwood (relaxing and warm); Teatree (antiseptic properties); Chamomile (soothing effect on nerves); Geranium (mood swing balance) and Bergamot (insomnia) (Tisserand, 1979).

Sensing an Improvement

Maddock's (1994) describes a study by a Registered Nurse on a gentleman in the terminal stages of motor neurone disease who was ventilated following a respiratory arrest. Although this disease is a progressive disease of the nerve cells which supply the skeletal muscle, the person is still able to feel sensation. He was massaged regularly on his face, hands, legs and abdomen with light sweeping movements which relax and

improve blood and lymphatic flow to and from the tissues. He was massaged in the mornings prior to his gruelling physiotherapy sessions with a blend of rosemary and neroli oils in sweet almond oil, to wake him up and lift his mood. The gentleman found the massage helped him cope with these sessions. In the evening, the gentleman was massaged just before sleep with lavender and geranium to help him sleep. He also found that he required no sleeping medication the nights he was massaged. This gentleman was able to receive relaxation and sensory enjoyment in the final stages of his life.

Desperate Need

In 1990 a woman having had a mild stroke and experiencing dramatic side-effects from taking long term steroids, decided to try an alternative therapy - aromatherapy. The woman's abdomen had swollen up, so she applied lavender and peppermint oil and watched her abdomen go back to normal in 24 hours. Massaging her feet also helped combat the dangerous hypertension that had led to her earlier stroke. She was able to come off medication and believes she is alive today due to the massage, oils and reflexology (L. Thompson personal communication, 30 July 1996).

Endometriosis and Oils

A British aromatherapist, Valerie Worwood, has used aromatherapy for the past 10 years in her clinic, for the treatment of women with endometriosis. This medical condition causes severe pain, heavy bleeding and trouble with conception. Worwood formulated a treatment plan using essential oils to suit the unique set of symptoms described by women. Adopting a holistic approach, she also included dietary advice and bodywork techniques to complement the aromatherapy treatment. She was amazed by the results and a pioneering trial was conducted with 22 British aromatherapists. The benefits proved to be a considerable reduction in pain and improved quality of life, with benefits continuing sometime after treatment was completed (Moffett, 1996).

Complementary Healing and the Benefits

Insomnia or Chronic Sleeplessness

By using the appropriate oils in either a bath, vaporiser or blending into the body with massage, aromatherapy can relax, soothe and sedate a person.

Pre Exam Study

By using oils such as rosemary, basil and lemon in a vaporiser, a person can gain clarity, focus and stimulate recall when studying.

Reducing Arthritic Conditions

Pain and stiffness in joints is aided with aromatherapy oils. By massaging the appropriate oils into the muscles or soaking in a bath, this treatment provides soothing, warming and anti-inflammatory healing to the patient. The oils also promote detoxification.

Skin Conditions

By cleansing, massage or bathing with oils, skin conditions, such as acne, eczema and dermatitis can be helped. The oils promote healing, strengthening, protection and regeneration of new skin.

Influenza, Headcolds

Using peppermint, lemon, teatree and eucalyptus oils by inhaling, blending or bathing can promote cleansing, clearing, antiviral and anti-infectious stimulants for the patient.

Conclusion

'Complementary therapies' are now an important part of nursing and health care practice.

Aromatherapy is used to improve quality of life at both the psychological and physiological level. It can enhance a person's life through the reassuring use of caring touch and pleasant aromas. It can promote a degree of relaxation that can aid the body with its natural healing process.

Aromatherapy provides us with a contemporary version of a healing art and is based on the premise that the best way to prevent illness is to strengthen the body's self-defence mechanism. Aromatherapy helps restore the harmony between body and mind, a harmony that is constantly sabotaged by the stresses of modern life and our polluted environment. In this way aromatherapy can positively affect the way we feel, look and think. All of us can improve our health and loving communication with sensual massage and other time-proven aromatherapy practices.

References

Blatner, B. (1981). *Holistic Nursing*. USA: Prentice-Hall Inc.

Dunn, C., Sleep, J. & Collett, D. (1995). Sensing an improvement: *Journal of Advanced Nursing* 21(1): 31-40.

- Jackson, J. (1987). Aromatherapy. Australia: Greenhouse Publications Pty. Ltd.
- Kaiser, D. (1995). Culpepper aromatherapy product manual. Auckland: Blackmores.
- Maddocks, W. (1994). The good oil. Nursing New Zealand 2(1): 10-12
- Moffett, W. (1996). Pioneering endometriosis trial. Pharmacy Today, 1: 22-25.
- Tisserand, R. (1979). The art of aromatherapy. (2nd ed.). USA. Inner Traditions.
- White, J. and Day, K. (1992). Aromatherapy for scensual awareness. NSW: Nacson and Sons.

Appendix

Description of Aromatherapy from Personal Experience

I decided that one way to gain more knowledge, understanding and material for writing an assignment on Aromatherapy was to experience it first hand.

I felt very apprehensive and vulnerable about having an aromatherapy massage because it was quite a personal thing to allow somebody else to touch, feel and massage my body. However I was encouraged to relax totally and let myself drift away with lovely thoughts in mind and for one hour to forget all those worries I had on-board.

The room I laid in was dimly lit with warm soft music in the background and fresh scented towels draped all over by body and the 'aroma' of perfumes abundant.

The aromatherapist gave me a choice of oils to smell and I settled on one for relaxing the nerves, de-stressing the muscles and giving a feeling of wellbeing.

The therapist appeared to work in a systematic pattern over my body, covering all areas from head to toe and massaging lightly with perfumed, but well oiled, hands.

It took me a while to relax but I did feel the perfume aroma was having a calming effect and the massage was loosening up the areas of tightness in the muscles. The warmth of the room and the soft music all definitely added to a therapeutic experience.

I did feel good - an hour of just relaxing and having nothing to do was in itself a pleasure, but the experience of soft music, pleasant perfumes and warm massaging hands, all added up to a very beneficial and enlightening hour. I had treated myself to something 'special' and it left me with an 'inner warmth'.

Beginning Journeys - Volume 3

An Ethico-Legal Dimension of Nursing

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Introduction

This article investigates the Health and Disabilities Services Act (1993) and the impact this has on a nurse in an acute medical ward setting. An in-depth analysis of the clause 'recognise the aims and aspirations of Maori' is undertaken. Focus is placed on the health of Maori people and the actual/potential affects hospitalisation has on the tangata whenua of Aotearoa/New Zealand. This article argues that although in 1986 the government advised its departments that future legislation proposed should include reference to the Treaty and implications for recognition of its principles, that its outworking in the Health and Disabilities Services Act is just tokenism. This article highlights major disparities in health care delivery to Maori as opposed to non Maori. Nurses receive comprehensive education to prepare them to work in a culturally sensitive way and this article discusses the moral and legal implications of endeavouring to give this kind of care.

Johnston (1994, 251) says,

"from the very moment nurses undertake to care for a patient, they are morally (and it should be added, legally) bound to act in ways which ensure that no undue harm comes to the patient, and that the patient's 'best interests' are maximised and protected."

In 1993 the New Zealand government passed an act of parliament which was to reform the public funding and provision of health and disability services for New Zealanders (The Health and Disabilities Services Act, 1993).

Its intent was to:

1. *secure the best health and health care including provision of support for those with disabilities so as to maximise their independence.*
2. *facilitate access to personal health and disability services.*
3. *achieve appropriate standards of health/disability services*
4. *recognise the aims and aspirations of Maori.*
5. *establish a national advisory committee to prioritise health care.*

Essentially, four regional health authorities (RHAs) with appointed boards fund health care services in their regions, purchasing services from public and private providers through contracts. Twenty three crown health enterprises (CHEs) have been established with government-appointed boards of directors. The intention is that CHEs operate as successful businesses. CHEs contract with RHAs to provide services in their area. Over recent years government funding for health services has dropped 10% (O'Connor, 1993).

Furthermore, (sect 34) the RHAs are to consult on a regular basis regarding their intentions, relating to purchase of services with individuals/organisations who both provide health services or receive them. This consultation is to be at the discretion of the RHA's. What this brings to mind, of course, is the wide scope for bias in the RHA's choice of whom it shall consult with. Cameron and Allison (1990) suggest that the right of Iwi under the Treaty is reduced to being consulted with when Government wants, and ignored even when it does advise.

Cameron and Allison (1990) go on to suggest that it is possible that Maori people selected to specific committees may find it difficult to challenge, or may not yet have formulated a political analysis of their own oppression. The result being, that Maori representatives may be unable to challenge the Pakeha majority. Taking Maori into these foreign environments alienates them from their Iwi and their support networks. Consultation may not truly express the obligation of partnership but merely attempts to suck Maori into the dominant system. This is a totally different approach to that of the Waitangi Tribunal. Discussion and dialogue are carried out on the Marae, within the culture of the group/tribe grieved.

In 1975 the Labour Government enacted the Treaty of Waitangi Act which established the Waitangi Tribunal. The Tribunal, whose powers and members were extended in 1985, hears Maori land claims against the Crown dating back to the Treaty signing date (Burgess, 1993). Doms (1989) highlights that to the Maori people their lands were closely linked with their spirituality and wellbeing. Rapid transfer of land to individual European settlers by way of the Native Lands Act 1862, and the New Zealand Settlements Act 1863, eroded the Maori concept of tribal ownership of land. Doms goes on to suggest that this loss of land resulted in the demoralisation of the Maori people and a fifty percent drop in their population by 1891. The Waitangi

Tribunal has been established to help redress these grievances and bring healing at a 'grass roots level.'

Walker (1986, as cited in Doms 1993) challenges nurses, as providers of health care, to address issues of culture and racism and the implications of the Treaty of Waitangi in relation to Maori health. Awareness and understanding of social, cultural and traditional values would therefore be promoted and nurses' ability to address health issues for a bi-cultural New Zealand would be enhanced.

The World Health Organisation defines health as: a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. Maori view of health is much broader being: a state of complete spiritual, mental, family and physical unity, harmony and well-being (Patrick, 1982). Maori people believe that these various dimensions cannot be viewed separately. They are interrelated to form a whole and are the cornerstones on which good health is founded.

Te Taha Wairua: the spiritual dimension of a person incorporating not only belief in God but communication with the environment, land, lakes, mountains and trees. Loss of land, for example, would indicate poor health for a Maori.

Te Taha Hinengara: the thoughts and feelings. Maori people find thinking in Western terms, of analytically reducing the whole into parts difficult, as their thinking has a wholeness concept. Feelings are expressed openly and words may not be necessary.

Te Taha Tinana: this incorporates care of the body. Physical health leans heavily on ritualised procedures, for example, a Maori mother is discouraged from cutting her hair lest some harm may occur to the growing foetus.

Te Taha Whanau: health is not seen to be individualistic but a reflection of the whole. Western view tends to be that a healthy person can stand on their own two feet, whereas in Maoridom, independence is seen to be poor health. Interdependence seems to be, for the Maori, a healthier goal.

Durie (1994) points out that although there is a Maori person on each RHA and possibly on CHE's, no emphasis has been placed on a negotiated partnership with Maori either in the formulation of health reforms or in their application. Failure to include the Treaty in health legislation reflects the Government's reluctance to recognise the Treaty as relevant to the whole social policy debate. It has brought concern to Maori that there has been no reference to the Treaty in the Health and Disability Services Act 1993. It would seem that this makes a mockery of the significant step the Government took in 1986 in recognising the Treaty in law by advising government departments that future legislation proposed should include reference to the Treaty and implications for recognition of its principles.

Cooney (1994) suggests that cultural safety provides a framework through which nurses can challenge monoculturalism within their own institutions, with the aim of addressing the power imbalance. Cooney's view can be illustrated in relaying the events encircling the death of a Maori woman on our ward. Relatives had been surrounding her bed for some days. At the time of death we endeavoured to give care in a culturally sensitive way by ascertaining from the relatives what they would like to do. The lady's daughter helped wash her mother and place her in the mortuary gown. We, as nurses, were faced with a dilemma in this situation as the Maori lady died during the weekend and the family wanted to take the body home. It seems that hospital policy is such that, the doctor who signs the death certificate must have seen the patient alive. A doctor who met with this criteria was unable to be found and the family had to wait until Monday to take their mother home. Explaining this bureaucracy to the family was excruciating. The family decided to stay with the body until the Monday when the doctor would then sign the death certificate. We negotiated with the Duty Manager (who is a nurse) and made arrangements for the body to stay on the ward till the Monday.

We, as nurses, endeavoured to give culturally sensitive care but we had a culturally insensitive environment to contend with. Cooney (1994) goes on to suggest that the health services are largely based upon a dominant monocultural orientation and, therefore, they are not providing services or information specifically tailored to the cultural values and beliefs of individual clients. I also find it rather alarming that written information in the way of pamphlets, discharge notes, instruction sheets outlining preparation for tests and investigations are all printed in English. A point in favour of the CHE is that there is an interpreter provided should a Maori person require it. Keene (1988) highlights a project that has been set up by management at Auckland Hospital to ensure the policies, procedures and systems of the hospital are designed to recognise and cater for the needs of all cultures. She goes on to say that nurses may have to accept that at times they may have to step aside to allow a Maori person without nursing qualifications to provide the care for some Maori patients, if those patients so desire. Basically it comes down to being willing to give up power.

The Public Health Commission (PHC) has been set up as part of the Health and Disability Services Act 1993. Its function is to meet the special needs of Maori, the aim being, that Maori health will, in the future, enjoy at least the same level of health status as non-Maori. One of the key objectives is to develop systems to ensure that culturally appropriate practices and procedures are an integral requirement in the purchase and provision of health services. Let's hope that these systems are developed with proper consultation with Maori and not just a paternalistic approach to the health needs of Maori.

Recommendations have been made by the National Advisory Committee on Core Health and Disability Support Services (1993) that RHA's may purchase aspects of Maori traditional healing where there is reason to believe that this will improve access to effective services for Maori and lead to better health outcomes.

This indeed is a positive step but the word may makes it optional for the RHA.

In legislation it is the principles of the Treaty of Waitangi which are acknowledged. These principles are partnership, participation and active protection. Partnership refers to an ongoing relationship between the Crown and/or its agencies and Iwi.

Participation is a principle which emphasises positive Maori involvement in all aspects of New Zealand society. Active protection indicates that responsibility to actively protect Maori interests belongs to the Crown. In health terms this is essentially about health promotion and prevention and seeking of opportunities for the enhancement of Maori health. It seems, that the Health and Disabilities Act is silent on Treaty matters, and in terms of Maori health, has a relatively ineffective statement acknowledging 'the special needs of Maori and other particular communities' (Durie, 1992).

Shipley (1996/97) highlights barriers which hinder access for Maori to Health and Disability Support Services. These are:

- ineffective communication about what services are available or how to access them
- unresponsive staff and services that do not meet Maori health needs
- distance and lack of access to transport
- cost of services
- lack of coordination and integration of services.

It is all very well to highlight these barriers, what needs to be done is proper consultation with Maori about how they would like the delivery of health care to be. What is commendable is that Shipley (1996/97) goes on to say that where feasible Maori women are to have access to cervical smear takers and educators who are Maori women. RHA's are to purchase locally coordinated health education, promotion and smear taking services for Maori women and their whanau. This is a step in the right direction.

So how does this analysis of the Health and Disabilities Services Act relate to moral and legal binding to act in ways which ensure that no 'undue harm' comes to the patient, and that the patient's 'best interests' are maximised and protected? Legally, it seems, even though there is very little in actual wording about our responsibility towards Maori in the Act, subsequent explanatory documents have spelt out active protection principles. According to the Treaty of Waitangi we are agents of the Crown and active protection, participation and consultation are our responsibility.

Woods (1992) highlights that much time has been devoted in recent years to the unique treaty arrangements between Maori and Pakeha made in 1840. Under the treaty, Maori have a right to appropriate health services - funded through the health system. Woods goes on to point out that an appropriate service naturally means a service which encompasses concepts of health that are firmly based in Maori culture. The crux of Wood's argument is that this requirement remains elusive, as it is for other disadvantaged sectors of the community. The analysis of the Act in the earlier part of this article bears this out.

I think it may be that we, as nurses, must now therefore come from a moral point of view. If the wording of the law can only allow one small sentence and the spelling out of that sentence uses words like should or may instead of must then the law is clearly biased against Maori. Nurses have the choice to pick up the moral issue of cultural sensitivity and run with it. If we are morally bound to act in ways which ensure that no undue harm comes to the patient then a thorough knowledge of what harm means to Maori must be investigated in depth. I believe nursing education has clearly done this. Understanding the holistic concept of Maori health, learning about Maori history and the events that devastated strong and vibrant people, and grasping what Maori want in the way of healthcare is a great place to start. When I nurse a Maori I am aware of not just the person but the wealth of culture that they bring with them into the ward. I try to stand back and facilitate healing rather than directing it. Conscious effort enables me to liaise with the appropriate family member and find out what the whanau want. This information is part of my bargaining power when I negotiate with doctors and other health professionals. So what does 'undue harm' mean. In the context of this essay it means that even though the law, hospital policy and medicine are stacked against Maori, my moral responsibility is to illicit from Maori patients what they want from their time in hospital.

Johnstone (1994) subscribes to the following view. She suggests that ethics (moral reasoning and decision making) is not just about solving 'big' moral questions but it is also fundamentally about how to be moral, and about how to encourage a more reflective, sensitive, aware, knowledgeable, empathetic, compassionate, kind, caring, just, wise and humane way of being, deciding and acting in health care contexts. She goes on to add that it is also about recognising human vulnerability and being committed to overturn the conditions contributing to it and to prevent avoidable suffering that can and does occur as a result of being exploited, overlooked or ignored. A great challenge for nurses!!!!

Conclusion

This article has investigated the Health and Disability Services Act 1993 with special regard to provision of health services to Maori. It demonstrates that although Government regards the Treaty of Waitangi as the founding document of New Zealand and a health document, that legally health providers can basically take or leave participation, consultation and active protection of Maori interests. It highlights aspects of Maori

perceptions of health, how loss of land has contributed to poor Maori health and how nursing educators have taken up the challenge to make cultural sensitivity part of their curriculums. Furthermore, this article examines ways in which nurses can ensure that no 'undue harm' comes to their Maori patients and that their 'best interests' are maximised. This is shown in the personal experiences of a nurse working in a general medical ward. We may not be able to change the whole system but we can deliver culturally sensitive care. And who shows us how to do this? The patient themselves.

Reference

- Burgess, M. (1993). A guide to the law for nurses and midwives. Auckland: Longman Paul.
- Cameron, D., & Allison, B. (1991). The context for women health workers in Aotearoa. In Fourth International Congress on Women's Health Issues. Massey University: Palmerston North, New Zealand.
- Cooney, C. (1994). 'Unicultural Orientation' versus 'Institutional Racism'. *Nursing Praxis in New Zealand* 9 (1): 10-11.
- Core Health and Disability Support Service for 1993/94. First Report of the National Advisory Committee for Core Health and Disability Support Services to the Minister of Health, The Honourable Simon Upton. Wellington: The Committee
- Doms, J. (1989). The Treaty of Waitangi as a health document. *Nursing Praxis in New Zealand* 4(2): 16-18.
- Durie, M. (1992). Maori Health and the State. Publisher unknown.
- Health and Disabilities Services Act 1993. Wellington: New Zealand Government.
- Johnstone, M. J. (1994). *Bioethics: A nursing perspective* (2nd ed.). Sydney, Australia: W.B. Saunders/Balliere Tindall.
- Johnstone, M. J. (1994). *Nursing and the injustices of the law*. Sydney: Harcourt Brace.
- Keene, L. (1988). Working against racism. *New Zealand Nursing Journal*. August, 17-19.
- O'Connor, T. (1993). Nurses face choices. *Nursing New Zealand* 1(6): 14-16.
- Patrick, D. L. (1982). Measurement of health. In Patrick, D. & Scambler, G. (eds). *Sociology as applied to medicine*. London: Balliere Tindall.
- Shiple, Hon., J. (1996/97). Policy Guidelines for Maori Health. Nga Aratohu Kaupapahere Hauora Maori. Department of Maori Studies. (1994). Te Kawenata o Waitangi. The Treaty of Waitangi in New Zealand society. Massey University: Palmerston North.
- Woods, M. (1992). Philosophical issues in primary health care in New Zealand. *Nursing Praxis in New Zealand* 7(1): 22-27.

Beginning Journeys - Volume 3

Journalling and Reflection

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This article was an assignment required as a summative assessment for Nursing Knowledge 1, a paper in the Bachelor of Nursing Transition course. We had been asked to evaluate current literature that discusses journalling and reflective practice, and use our own personal journal entries to explore themes and how our personal learning has been enhanced.

As a part time clinical tutor, I had been actively using journalling and reflection in my work with the Stage 1 and Stage 2 nursing students, but not until I actually undertook this paper, and researched more about journalling and reflection, did I gain more of an understanding and insight into how I could extend both myself and the students I was working with.

Perhaps by reading this article, you too can gain some different perspectives, that may make journalling and reflection less of an academic requirement, and more of a "real" learning process.

This paper will discuss how critical reflective practice can be both beneficial to the nursing practitioner and their clients, but also point out a few considerations for reflection to be effective, and perhaps an alternative that may be equally effective, depending on one's ways of thinking.

Some of the writer's journal extracts will illustrate some perspectives and critical reflections that lead to changes in her personal practice.

What is Journalling and Reflection?

Journalling is used extensively in today's society, not just by the nursing profession. Putting thoughts and actions to paper and keeping records of day-to-day events, or special events, is a practice many individuals undertake.

Holly (1987, p.17) talks about journalling as "taking snapshots of our lives", and that these "snapshots" can be used in a variety of ways, hopefully contributing to improvements, changes and identifying patterns in our behaviour. Educationalists and scholars have used this process of looking at events, to gain insight into their and other people's behaviour for many years. Why is this important to the nursing profession?

In today's teaching institutions, journalling and reflection are considered an important part of the student's curriculum, and this covers many professions, not just nursing. Boud, Keogh and Walker (1989), wrote one of the first reference books expounding why journalling and reflection is so important in the learning process. Their field primarily is the teaching profession, but since the 1980's many of their ideas and strategies have filtered down into other professions; nursing theorists and practitioners have quickly grasped the ideas offered. Boud, Keogh and Walker say that reflection is pursued with intent, and there must be a goal or purpose to the process. How is this different from day-to-day journal keeping that many people keep routinely?

Reflection, according to Street (1991), is the process of reproducing an image, making meaning of that image, and the relationship of that image to others concerned. She stresses that the relationships are complex and coexistent, and need examining to fully understand them and to learn from them.

The "image" we reflect from can be an event of any importance, but it is the ways that actions are transformed, that is important, especially in a nursing capacity. Street goes on to say that it is the "potentialities" of nursing practice that benefit from the examination of the images created.

But can we learn from images that may be distorted by our own perceptions through reflection? Holly (1987, p.17) says that "reality depends on perspectives and perspectives are interpretations of data generated through the senses." So how are perspectives gained so we can reflect without distortion?

Benner (1984), Holly (1987), Patterson (1991) and Street (1991), all speak about experience and knowledge gained through practice and ask that without some background knowledge on the image being reflected on, how can we effectively learn from reflection unless we have reached a certain level of expertise? Holly (1987, p.29) states "to be a critic one must be a connoisseur ... this is an appreciator of significant aspects and elements of teaching and society ... "

This can be contradicted in some cases by an individual, who not necessarily of nursing background, but possesses "life skills", and maturity, (not necessarily of years), who can look at a situation in a more lateral way of thinking, and give different perspectives. Street (1991) talks about the actions of the past and present influencing actions of the future, and these are important to understand how we are shaped by the past. Do we need to be "experienced" or "proficient" (Benner, 1984) practitioners to reflect? Many nursing students show wonderful insight into many perspectives of nursing practice, including human nature and frailties, and ethical dilemmas, even at a "novice" or "beginning" level.

Personal Journal Entry - 1995

"Today we were talking our clients on an outing. I had organised the minibus, and made sure of all the logistics ... there seemed to be a huge amount of communications with ...

T had asked if she could take Mrs C on our outing. I was surprised, as Mrs C was completely blind, and we were going to see the sea and have an ice cream at a cafe. T had another client, and as bus seats were in short supply, I suggested she might like to take her other client. T was quite adamant on taking Mrs C, and on reflection I was very pleased she did, and ashamed on my behalf. During the bus trip, T sat with Mrs C, with the window open, held her hand and spoke to her all the way, what people were doing, colours, new buildings, etc.

When we arrived at our destination, it was a huge effort to get Mrs C out of the bus, but T and I managed. We sat her in the sun, facing the sea, with the waves crashing and the seagulls wheeling around. She ate her ice cream, looking so happy even though it dribbled down her arm. I had prejudged T, because of some of her previous immature actions and comments, but she had really shone through for Mrs C. I praised her later, saying how special the day had been for Mrs C, and how proud I was of T, and made a mental note not to prejudge "novice" students so much. Perhaps I had been so caught up in the organising I had lost sight of the real purpose?

It was great to share with T's journal entry later; she had put herself into Mrs C's body and become her "eyes", and received different images and perceptions because of this. I felt very honoured today to be doing what I am doing, and getting the opportunity to "learn" or revisit again."

Carper (1978, as cited in Johns 1995) and Pearson (1994) say that nursing knowledge is gained through practice and reflection and the process is very sophisticated, incorporating a variety of patterns of knowing. So to be emancipated, does the nurse have to gain nursing knowledge to work through the various patterns both internal and external to the image?

If these patterns are not clear, or the areas of practice become "swamps" (Schon 1987, cited Street, 1990 pg. 378), our nursing practice becomes complicated and therefore we develop high levels of practice to cope and extend ourselves. This is to say that clinical nurses develop and adapt their own nursing practice according to the changing situations, therefore developing their ways of knowing and expertise.

Nurses as a Verbal Society

Nurses in the past have and still are a verbal profession examining difficult or unusual perspectives with other colleagues usually over a coffee or meal break, gaining different ideas and perspectives from others in this way. Is this because nurses have traditionally been a Female dominated profession and this has been our "ways of knowing" as stated by Belenky, Clinchy, Goldberger, and Tarule (1986)? These authors talk about "received knowledge" and "mutual stretching", allowing us to gain richer vision and changes in perspectives, using our auditory and verbal skills. So, do we need to be journaling to be reflective, to gain insight and change over our practice or perspectives?

Critical Reflection

Reflection is at best complex, suggests Boud, Keogh and Walker (1989), and negative feelings can form barriers to our learning and changing perspectives. It is interesting to find in the Canterbury Public Library computer files, over 79 titles (March 1997), starting with "Reflections of ..." ranging from reflections of holidays, gardens, life-changing events, and so on. Perhaps the writing is a healing process for some of these authors, and part-in-parcel of the reflection in action process?

Taylor (1989, p.1), says that "In writing we bring knowledge into being, we record and preserve it. Writing is the seed, the fruit, the pickle of our understanding."

To reflect on our journals, we can do so individually or in a group situation. To reflect individually takes a great deal of commitment and insight into different perspectives and our own perspectives can be faulty due to our own impressions or emotions. We can have high ideals of journaling and reflecting by ourselves, but when we get into the habit of journaling about negative issues or issues we feel strongly about, we cloud our own judgement. The following journal extract shows this.

Personal Journal Entry

"The atmosphere is very different when X the RN is on duty. I suppose it's good she only works a couple of days, but we all know about it when she is on! As soon as I walk up the steps I can sense the atmosphere, the carers are all very quiet and subdued it doesn't bode well for the day!

X was very objectionable to both myself and the students the other day, so I'm not looking forward to a repeat episode, and am on edge already.

I really should make an effort to talk to this woman today and find out if there is a problem that I can help identify or solve there may not be a problem with me at all, she may have troubles at home that no one is aware of and are personal, I really know very little about her. Does she want me involving myself, or is it positive and pro-active of me to do so? How would I react? I have written a few things in my journal about incidents involving X, and they are all angry and negative and I don't feel positive enough to address them

at present!"

When we reflect as a group, the emphasis is taken away from the writer's perspective and other views are given. Habermas (1974, as cited in Boud et al, 1989 p.25), calls this "critical intent", when others bring their informed judgement to view issues or problems. This stops what he calls "self deception" but depending on the group, there can be "collective deception" especially when the group is one of peers and close to the image or problem themselves.

To be Critical in Reflection

Grundy (1982, as cited in Boud, Keogh and Walker, 1989) says that relationships between the writer and participants in the group are very important. If the purpose of critical reflection is to guide the process to empowerment and emancipation, that leads to improved nursing practice, as suggested by Allen (1985, as cited in Emden 1991), how do we make the reflective group effective?

Sutton et al, (1996), suggest how group relationships can be more effective. There needs to be a sense of purpose to the group, the meetings are to critically reflect the images presented, not the writer. To be critically reflective the group needs an understanding of the critical social paradigm, and is able to look at different perspectives. Confidentiality is respected, and the environment is non-threatening. Ideally the group builds up a rapport with each other, so individuals feel less threatened by exposing their emotions in their writings.

Strathie and Holmes (1996, p.1) say that reflecting is telling others and ourselves "who and why we are". Although we may feel quite uncomfortable at times, unless we are put out of our comfort zone sometimes, we may not really look into our own practices. They use the word "story" instead of reflection or "exemplar". They say that a "story" is recollecting, articulating, and reflection of an event or an image, and the telling of the "story" heightens self-awareness and is realistically attainable.

It is the expectations of being "critical" that discourage nurses from journalling and reflecting? If we were asked to tell a "story" would we respond better as a culture? Our profession is ingrained in verbalisation about everything from the so-called mundane everyday activities, to life threatening or joyous experiences.

Strathie and Holmes (p.101) suggest that "story can be used casually or systematically ... it is a process and a medium." It is the systemic approach that ties in with the critical approach, but perhaps "story" is more attainable to nurses who may be threatened by theory and theorists.

Collaboration

Collaboration is a term used by several writers including Street (1991), Case (1994) and Belenky, Clinchy, Goldberger and Tarule (1986), to describe a group, that come together to reflect. Ideally these individuals bring varying strengths and understandings to the image being reflected so there is a critical image or perception, rather than just one perspective, or an interpretation of contributing to the "status quo" (Street, 1991), that undermines our nursing practices. Using colleagues can also help pinpoint a hidden agenda that may be inherent to that profession. When other perceptions are gathered from individuals from differing backgrounds, very different perspectives are gained.

The following journal entry and subsequent reflections pertain to this view well. To clarify, here is a small bit of background knowledge.

Working in this particular area had been a bit difficult due to a number of reasons, but the older registered nurse had been particularly unhelpful to the students. She felt very threatened by their assessment of clients, and the students also wanting to write in their care plans. She had in fact 'binned' their daily notes on their client with the words "only the RN's write in the patient's notes". There were a lot of political considerations, and the fact that the writer was a relieving tutor and had not built up a rapport with this woman had not helped. The students had asked several times for advice from her, but she had not reciprocated very well, so communication was a problem.

Personal Journal Entry

"T asked me if she should take Mrs Y's BP. She had been asked on a couple of occasions if she had done so, as it was required as part of her overall assessment of her client. She said that she and another student had attempted to on an earlier occasion but the client, who was elderly and confused, became upset. We talked as to why it was important, especially as T had only been able to find one BP entry in Mrs Y's notes and that was 190/120. I had no reason to disbelieve her as Mrs Y was her third client and she was usually very good at finding her way around the notes.

We talked through the procedure, and T seemed to be OK about it all, and I had seen her take another client's BP and knew she was quite capable.

Mrs Y was sitting in the dayroom, and we decided to leave her there as she had walking difficulties and we were trying to disrupt her as little as possible. T asked Mrs Y if she could take her BP, to which Mrs Y replied "she didn't like it". She didn't say no, and in view of her 190/120 recording, I decided that we should carry on. T was starting to get quite nervous, so I calmly talked to Mrs Y while T put the cuff, etc on. As T started to inflate the cuff, Mrs Y started shouting, no real words, just noise. I continued to talk calmly to her, asking her if it hurt, she said no but, "didn't like it". I was trying to encourage T to continue, which she was doing,

but reluctantly. As a more proficient nurse, I could have taken the BP reading with the noise, but T was having problems. All of this had only taken a couple of minutes, but Mrs Y was still making noise.

The next second O, the RN came rushing over and shouted at T to stop as Mrs Y "didn't need a student doing that". I calmly explained that T was nearly finished, we weren't hurting Mrs Y but she didn't like the tightness. Mrs Y, who recognising O, now started to scream, made matters worse! There was no point on carrying on now!

T was absolutely shaking in her shoes, and I was trying to calm her and Mrs Y, and also talk rationally to O.

We had a group discussion later, and T was angry with me for putting her in that position. We discussed all the ins and outs of the situation, which appeared helpful, as she later journalled and used the article to describe changing perspectives. I was very angry with O for interfering although she felt she was protecting "her" client, even though T was looking after her for the duty.

I have reflected over this several times in the last few days and there are a lot of things I would change, mainly the communication with O, explaining our intentions, and perhaps removing Mrs Y to quiet place.

It has been a huge learning curve for me and certainly I will be changing my teaching practise because of this ..."

When the writer asked a couple of close colleagues, who work in the same sets of circumstances, for their opinions and advice on this matter, their replies were very sympathetic, and identified strongly with the writer's perspectives and feelings; which was reinforcing in some ways, but not helpful to learn from.

When a different set of individuals were asked to comment and reflect, the different perspectives were enlightening, and a number of different perspectives were gained.

Here are some short quotes from those individuals:

D ... "I would have checked the BP in the notes myself, I deal with numbers all the time, and only trust my own sets I have worked out ..." (Bank Manager and brother of writer)

F ... "I would have taken the BP myself. I felt the patient was at risk with a BP that high, and I would have wanted to check it myself rather than letting a student."

(Staff nurse, friend and colleague of writer, who is currently working in an acute ward in a public hospital.)

G ... "as a teacher one has to become less emotive ... You should set limits on how much of any teaching situation you take to heart."

(Educational manager of a Christchurch private tertiary institution)

E ... "from a critical social theorist perspective, you should examine what historical and social political forces stopped you from confronting this RN for her behaviour ..."

(Full time tutor at Christchurch Polytechnic, from a critical social perspective)

These varying perspectives have allowed the writer a far better understanding of the situation, and hopefully her practices in the future.

Skeins of Wool Theory

Street (1991) uses the metaphor of critical reflection being likened to untangling skeins of wool. There are threads of complexity of relationships, and tensions are tested in the untangling process resulting in decisions being made to continue or cut the thread.

If we have different angles of perspectives, different strengths can be utilised, to the benefit of the image, and the learning process can be an extension in itself. This was useful in the above journal entry.

Excellence in Nursing

It is important to remember that although journalling and reflection is becoming part of our nursing culture, there seems to be an emphasis, in some areas, to "celebrate moments of nursing excellence" (Harvey and Tviet, 1994, p.53). Because of this focus, Benner's Domains of Expertise (1984, as cited in Harvey and Tviet) are used to illustrate and identify with moments of "excellence in nursing".

Does this mean that nurses who exemplar and take part in these "celebrations", will need to be "proficients or experts"? Or only those exceptional experiences are reflected on and the negative ones ignored as being too painful or exposing one's self and nursing practice?

Summary

There is becoming more literature available about journalling and reflection in the nursing area, as different practitioners and theorists grasp the ideas, and use them in their own areas in different ways.

The overall theme from what this writer has gathered from the small amount of material she has absorbed, is that critical reflection is necessary to extend ourselves as individuals and the nursing profession as a

whole.

There are limitations to this, as context is very important and an understanding by the reflective group to processes and to give different perspectives of the image. Can we be critically reflective in just a group of our peers?

In this article there has been no discussion about the increasing awareness of the ethics of sharing journal entries, the writer would have exceeded the word count many times, and still not fully addressed the issues! Ethics are, and will continue to be, discussed by other writers, as awareness and legal implications arise and changes are made accordingly.

Ideally we need to revisit the image and look at the different coloured "skeins of wool", therefore time and opportunity has to be made to do so, plus a commitment to spend that time and energy. Does this by default give the reflection process to the academics or theorists, rather than the practitioners? Does this in turn defeat the whole ideal?

Cox, Hickson, and Taylor (1991), suggest that reflection is only helpful and productive if we are able to change our understandings and actions in practice, and we then become aware of our potential and own self imposed restraints in practice.

If time to do so is made an issue, or constrains us, then reflection will become a chore and an ideal rather than a practice in action.

De Bono (1993, p.182), suggests that parallel thinking works on the emphasis that the search is for possibilities - agreement is not always required.

"If you believe that action springs directly from "what is" then you are not concerned with the design of action? If you believe "what can be" has to be designed, then you apply the design process to action itself".

This seems to epitomise the concept of critical thinking but from a different angle, is it so different?

The last journal entry may show some signs of the writer's awareness of change some perceptions and ideals, and to extend herself in different areas of her practice.

Personal Journal Entry, November 1996

"I went off to help make the bed while M was in the shower. As I striped the bed down and started to remake it, I noticed some dry grass clippings in the clean sheets. Initially I was quite horrified, how did they get there, this was a hospital my biomedical model was shining through! As I brushed the dry grass off the sheets, I rethought the issues. The grass was dry, and there were no marks on the sheets at all. The sheets felt lovely and fresh, obviously the laundry staff had hung them out in the sun making the most of the fine weather. The lawns had been freshly mown, and it would be so easy for the ride-on machine to flick a bit of grass either onto the sheet or the laundry basket. The client whose bed that I was making, had no broken areas, and this was a rest home after all, not a sterile acute ward. If I had thrown the sheets back into the laundry, it would have run down acutely low number of the sheets available, and it didn't seem worthwhile. Hopefully the client might have some awareness, even subconsciously of the sun-dried sheets and fresh smell, would it make them feel homesick or even aware? I later casually asked the laundry staff if they had been making use of the lovely weather, and they said it also cut down the costs of the running of the place. I hadn't thought of that issue, being more aware of the client's side of things, but in the big picture the rest home is that, a large home trying to cater for a large amount of peoples needs. I hoped that by the time I was in a rest home, I too would be able to have fresh smelling sheets, to make it more 'homely' and perhaps bring back memories."

References

- Belenky, M., Clinchy, B., Goldberger, N., and Tarule, J., (1986). Women's ways of knowing: The development of self, voice and mind . United States of America: Basic Books.
- Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison Wesley.
- Boud, D., Keogh, R., and Walker, D., (Eds). (1989). Reflection: Turning experience into learning. New York: Nichols.
- Case, B. (1994). Walking around the elephant: A critical - thinking strategy for decision making. Journal of Continued Education in Nursing 25(3): 101-109.
- Cox, H, Hickson, P. and Taylor, B. (1991). Exploring reflection; knowing and constructing practice. In Gray, G. and Pratt, C. (Eds.). Towards a discipline of nursing. Melbourne: Churchill-Livingstone.
- De Bono, E., (1993). Parallel thinking: From Socratic to De Bono thinking. London: Penguin.
- Emden, C., (1991). Becoming a Reflective Practitioner. In Gray, G. and Pratt, C. (Eds.). Towards a Discipline of Nursing. Melbourne, Churchill-Livingstone.
- Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in

nursing. *Journal of Advanced Nursing*, 226-234.

Harvey, C., and Tveit, L. (1994). Clinical exemplars to recognise excellence in nursing practice. *Orthopaedic Nursing* (4): 45-53.

Holly, M. (1987). *Keeping a professional journal*. Geelong: Deakin University Press.

Patterson, B. (1991). *Excellence and expertise in nursing*. Geelong: Deakin University Press.

Pearson, A., (1994). *Reflective practice: The intellectual pursuit of nursing in action*. Summary of a Keynote Address presented at the First National Nursing Academic International Congress Canberra. p.1-6.

Straithie, L., and Holmes, C. (1994). Story as a reflective process for nurses. *International Journal of Nursing Practice*, 99-104.

Street, A. (1990). *Nursing practices: High hard ground, messy swamps and the pathways in between*. Geelong: Deakin University Press.

Street, A. (1991). *From image to action: Reflection in nursing practice*. Geelong: Deakin University Press.

Sutton, F., Smith, C., Wright, K., Arbon, P., Eldridge, K., Forbes, D., Robbilar, N., and Zeitz, K. (1996). Discovering and affirming knowledge in nursing practice. *International Journal of Nursing Practice*, 63-70.

Taylor, G. (1989). *The students writing guide for the arts and social sciences*. Cambridge: University Press.

Beginning Journeys - Volume 3

Complementary Healing Water Therapy - Hydrotherapy

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Introduction

"The ultimate state of health would seem to be a delicate balance of all dimensions - physical, psychological, sociocultural and spiritual (Potter & Perry, 1993, p.1002).

Holism is an essential element of nursing today that envelops all of the four dimensions as mentioned above. All are as important as each other and work, towards the ultimate state of health.

This essay will look at the complementary healing therapy, Water Therapy, also referred to as Hydrotherapy in relation to holism. The history and therapy will be described with examples of how water therapy is used. The application of the therapy and the benefits will be discussed.

Holism

. . . is a conceptual framework that, views healing as a whole concept which is made up of connecting parts. It is an anti-reductionist model that can be understood as a hierarchy of levels with each level being interdependent (Levant & Shlien, 1984). Therefore, holism in relation to health means linking mind, body and soul; it means taking into account the biological social, spiritual and psychological dimensions of a client. Nursing in a holistic framework would involve not dealing with a problem in isolation, but dealing with the whole (Levant & Shlien, 1984).

"The parts of the whole are necessarily, altered by their participation, in the larger whole. Holism seeks to elaborate the relations within and between part-whole unities" (Levant & Shliein, 1984, p.207).

The healing therapy chosen to illustrate this concept of holism is Water Therapy.

"Use of selected holistic interventions such as water therapy . . . enables nurses in any setting to maintain professional standards and offer additional alternative interventions to their specific patient population" (Mornhinweg & Voignier, 1995, p.207).

History

Water therapy (Hydrotherapy) is such a natural effective medicine, that it is not surprising to find that it dates back to the temples of the Greek god of medicine, Asclepius. Hypocrites drank a lot of water as a way of reducing, fever and as an alternative method of treating diseases. He discovered the therapeutic value of varying temperatures in baths and how this could help combat illness. The Romans also found water therapy therapeutic.

"A series of cold baths are known to have cured the Roman Emperor Augustus of a battling disease that had resisted all other remedies" (Buchman, 1994, p.8).

In the early 19th Century Vincent Preissnitz, a Silesian farmer, and teenager at the time, paved the way for water therapy today. In 1930 the first clinic for the treatment of Rheumatic Disease was opened. The recognition of pool therapy is due to Roosevelt who suffered from Poliomyelitis. He used water therapy to aid in his recovery and achieved good results (Australian Physiotherapy Association, 1990).

Therapy

Hydrotherapy is the use of water, whether hot, cold, fresh or mineral for therapeutic purposes. It is a blanket term for a whole range of treatments. It can be part of a treatment programme used by physiotherapists for clients after injury or operations and for some medical conditions (Australian Physiotherapy Association, 1990). It can be part of our daily activities, for example drinking water, or it can be a long soak in a hot bath which acts as a relaxant/soother by enhancing circulation, relieving pain and overcoming sluggishness (Buchman, 1994).

"Heat can sedate, quiet and soothe the body under many, conditions.

A short hot-water application depresses and depletes body, and muscle tone making the body feel relaxed" (Buchman, 1994, p.7).

Each of the distinctive physical forms of water - ice, water and steam has its own specific function in healing and in maintaining good health. Depending on its form (liquid, solid, gas), temperature (cold, hot, ice or neutral) and pressure (light or jet) water will have a specific physical and chemical reaction on the body (Buchman, 1994).

In a clinical practice of physiotherapists, hydrotherapy usually takes place in a heated swimming pool, a

temperature of 34-35°C and can be said to be specifically designed for an individual to improve neuro-musculoskeletal function conducted and supervised by a physiotherapist (Australian Physiotherapy Association, 1990).

"Hot water is more than just a convenience. Used properly it is a powerful therapeutic tool (Horay & Harp, 1991, p.8).

According to Buchman (1994), water therapy is a system of natural heating. It uses the body's need for water and its physiological responses to water to prevent, correct and treat a broad range of health and injury problems.

"Water therapy, uses stimulation -with water to produce subtle changes in energy. All non-drug healing methods work to transform static states (illness) into active states" (Buchman, 1994, p.xii).

Mode of Treatment

Hydrotherapy works by allowing buoyancy which relieves weight from the joints and supports the body. Because of the weightlessness effect, a greater range of movement is then possible, which may not otherwise be achievable out of the pool (Australian Physiotherapy, 1990). The warm water can produce many physiological effects, some of these being the relief of pain and muscle relaxation.

Hydrotherapy also relies on the properties of water to facilitate floatation. The properties of floatation and buoyancy reduce the pull of gravity the warm water reduces muscle tone, which then leaves the patient in a supported position which in turn aids reduction in stress and tension (Australian Physiotherapy Association, 1990).

Water has the ability to work directly on the whole body or it can act in a particular area. (Buchman, 1994). A physiotherapist is able to encourage the patient to position themselves in the way that is most beneficial to relieve the injury or stress (Australian Physiotherapy Association, 1990).

The benefits water therapy can be seen in clinical terms. After immersing in hot water the body takes a few minutes to adjust, which then brings about an increase in blood pressure. The blood then rushes to the surface of the skin where it is warmed by the hot water, causing the blood vessels to expand. This causes a decrease in blood pressure. The warmed blood penetrates deeper into the tissue below the skin, bringing more oxygen. It is this extra oxygen that causes the soothing, relaxing sensation, even to the tightest muscles and enables the free-or movement necessary for exercise and stretching. Simultaneously the muscles relax, the nerves are soothed and relief of pain is experienced (Horay & Harp, 1991).

Clinical Setting

Nurses use water therapy in a clinical setting every day but sometimes do not, view it as a form of therapy. An example of this is in a rest home where the writer has taken part in implementing this technique.

An elderly client was suffering from severe Arthritic pain in the left shoulder. The client was given a shower and was positioned so that she could gain the optimum benefit of the hot water. The water was turned on, and by altering the flow of the nozzle the water sprayed on her left shoulder for about 5-10 minutes. The client commented on how the water helped to relieve some of the pain, and made it easier to move.

Another use of the water therapy would be the use of a spa bath. This would be most beneficial in a situation of someone suffering back or shoulder pain to aid in the relief and relaxation. This situation has been used in the same rest home and is found to have encouraging effects on clients who look forward to having a spa for those very reasons. There is also the use of water therapy, by way of a warm spa/bath in a paediatric ward. It is an excellent way of calming a child down.

Wound cleansing is an important part of wound management and another setting where hydrotherapy is used (Trevelyan, 1996). It is an area where hydrotherapy is regarded as an advantage because it doesn't place any direct pressure on the wound. The type and site of the wound will determine which technique is most appropriate with the aim being to choose the technique that will cause the least trauma.

"Wound management has become the preserve of nursing and decisions concerning when to clean and how to clean a wound are largely taken by nurses" (Trevelyan, 1996, p.46).

A local hospital provides another example of hydrotherapy in a clinical setting. Here the physiotherapist is able to use the special hydrotherapy pool for clients from a wide range of groups. The writer participated in an antenatal group to get a feel for the benefits of hydrotherapy. The course offered a gentle exercise programme that enabled mothers to exercise without causing any pain or discomfort to themselves with the aid of both the buoyancy and floatation. On completion of the one hour session the mothers commented on the benefit of the weightlessness and how it gave them a boost of energy, ready to start the day. Although this is not an example of a nurse using hydrotherapy it does show the uses of it.

Benefits

The benefits of hydrotherapy are varied. Depending on the water temperature, the physiological effects will range from a sedating soothing effect to a stimulating, invigorating effect (Horay & Harp, 1991).

An example of a restorative benefit would be the use of cold water. According to Buchman (1994) this can

be achieved by a variety of methods, cold water treading or hot and cold contrast showers.

"Cold water . . . restores body tone"

"To improve your energy levels and vitality use a coldwater tread" (Buchman, 1994, p.40).

Another benefit is detoxification. By immersing in a hot bath, the body uses more oxygen which in turn aids detoxification through perspiration and breathing (Horay & Harp, 1991).

"If you wish to produce perspiration to eliminate toxins, bacteria or disease from the body, warm or hot baths are effective" (Buchman, 1994, p.46).

Relaxation would have to be one of the most common benefits. The ability of warm water to sedate and relax the body, whether it be to relieve pain or stress or simply to take time out has a similar effect to a tonic (Horay & Harp, 1994).

"Slipping into a warm bath . . . it reminds you to let go of mental and physical tension, to give up all the striving and activity" (Horay & Harp 1994, p.7).

Buoyancy-floatation provide the ability to achieve movements that may be unachievable out of the water. It provides either assistance in or resistance to movements performed under water (Haralson, unknown).

"Buoyancy, will assist movements toward water surface and resist movement away from the surface... therefore buoyancy can assist, resist and support movements" (Haralson, p.12).

Water also improves physical injuries. Placing ice on an injury, like a sprain, strain or fracture has a numbing effect and reduces swelling (Bushman, 1994).

"The cold helps to control the bleeding and reduce subsequent swelling" (Bushman, 1994, p.7).

The obvious advantage of many forms of hydrotherapy is the relatively low cost and its availability as close as turning on a tap (Buchman, 1994).

However, it must be noted as a caution, hydrotherapy is not appropriate in all cases. For certain patients, for example, a patient with severe cardiac complications, the effect of hot water can be detrimental (Horay & Harp, 1991). Otherwise the physiological effects can be very rewarding, relaxing and most beneficial.

Conclusion

Although hydrotherapy dates back to the Greek god, the healing properties of the water have only relatively recently been recognised and acknowledged. Taking a bath may now be a conscious therapeutic action as well as a form of personal hygiene.

"Holistic therapeutic nursing interventions expand the nurse's repertoire of therapies to promote health and augment or replace standard pharmacologic interventions (Mornhinweg & Voignier, 1995, p.20).

References

- Australian Physiotherapy Association. (1990). Clinical standards for hydrotherapy 36(3): 207-210.
- Buchman, D.D. (1994). The complete book of water therapy. USA: Keats.
- Haralson, K.M. (unknown) Therapeutic pool programs. Clinical Management 5(2): 10-13.
- Horay, P. & Harp, D. (1991). Hot water therapy. USA: New Harbinger Publications, Inc.
- Levant R.F. & Shlien J.M. (1984). Client centered therapy and the person centred approach. USA: Praeger.
- Mornhinweg, G.C., & Voignier, R.R. (1995). Holistic nursing interventions. Orthopaedic Nursing, 14(4): 20-24.
- Potter, P. A. & Perry, A. G. (1993) Fundamentals of nursing: Concepts, processes and practice. (3rd ed.). USA: Mosby Yearbook Inc.
- Trevelyan, J. (1996). Wound cleansing: Principles and practice. Nursing Times 92(16): 46-48.

Beginning Journeys - Volume 3

Case Management: The Model

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As the political landscape of New Zealand changes from a left wing welfare ideology to a right wing individualistic ideology, all aspects of public services have been overhauled and reassessed for both better and worse. This paper will look at one specific change of many within the health system, that of the advent of case management. A look at what preceded case management, and what case management is, will follow. The possible effects of case management on the providers and the consumers of health care in New Zealand will be discussed.

The health system of fifteen years ago, or even ten years ago was quite different to the health system of today. Then the focus was on health as a service of the state to its citizens. Nationhood as an ideology involved a health system that treated the sick irrespective of financial gain or loss to itself. However as the sick grew more numerous and the treatments available more complex and technical, a centralised state funded health system became a costly liability. In the oncoming wave of the new right, the health reforms were embarked upon, only instead of bringing a fully funded institutionalised system based on free treatment for all, it heralded the era of individual responsibility, individual choice, and the individual who pays.

It was from the pressure of financial cost that case management was forged in the United States of America, there the spiralling cost of health care was crippling the profit margin of the many private businesses that make up their health system. Because the New Zealand system was now to be run along business lines, then concepts which worked within the ultimately capitalist icon that is the United States of America could also be applied here due to the ideological similarities. Terms like providers and consumers took over where hospitals and patients left off.

Case management is a way for health providers to deliver on-going care without having the expense of funding a centralised institution. Instead, those that need health care can stay within the environ of the community. Rothman (1991, p. 520) describes it as a "practice modality that cuts across such human services as mental health, aging, child welfare, health and developmental disabilities". In a practical way case managers act as a hub for a myriad of resources from which a consumer may utilise. Consumers who require a case manager usually have numerous multidisciplinary needs and it is the role and responsibility of the case manager to organise the fulfilment of these needs by connecting these services with the consumer (Moxley, 1989).

This approach differs from the traditional system whereby the patient was admitted to an institution, for example a hospital, and the requirements of that specific patient were attempted to be met within the bounds of that institution. Here we can see an advantage for the health consumer, that of flexibility. Rather than being forced into a mould of available resources from one institutional entity, a consumer with a case manager can negotiate a wealth of resources from both private and public providers, and also a wealth of resources that include many disciplines. In this way a case manager could aid in making available a rehabilitation assessment and program as well as quality affordable housing. Both are important to a consumer's well being, but a traditional hospital would only make available the resource within its sphere of expertise, thus leaving the consumer to negotiate housing through a different agency not in contact with the hospital.

This leads to another advantage of case management, that of defragmentation. Because a case manager has the freedom to do what an institution can not, that is to liaise with the varied resources necessary to a consumer, the consumer has the buffer of the case manager between the confusing fragmented agencies and themselves, thus providing consistency and security. Also the case manager can gather around the various agencies and share information relating to the consumer's welfare rather than the separate agencies all equally left isolated from one another. This consistency is especially important for those consumers without the personal resources of accessing complex bureaucracies, for example the mentally ill. Case managers also have the information regarding varied agencies, the knowledge of their existence may be something that a consumer is lacking, or perhaps something just as simple as an agency's phone number or address.

Case managers are in this way able to provide a holistic level of care, making sure that each individual is treated as a person with multifaceted issues, problems, successes and strengths. A consumer has a consistent factor in their care within their own community with all their supports readily available, like family, friends, and neighbours. It also enables a consumer the self confidence to have greater input and self-direction into their own care because they are within a familiar and comfortable environment, rather than an impersonal, strange institution (Litchfield, Connor, Eathorne, Laws, McCombie and Smith, 1994).

But what of the providers? Case management was created in response to health providers needing a more efficient method of delivering services to their clients, thus it could be assumed that there are some benefits

to the agencies that employ a case management practice model. One such benefit is that a case management model is less expensive to fund than a centralised model. One reason for this is that the government does not have to fund overlapping services but can contract out to private profit focused (and thus supposedly more efficient) agencies for the provision of services, even the case managers themselves can be privately based, thus coming into line with the new ideology of market forces shaping an ever more efficient provider-consumer relationship.

As the medical profession makes advances it also allows more clients to be treated in community settings. This is especially relevant to the mental health sphere, and there has been much publicity of the deinstitutionalisation of many of the mentally ill. Rothman (1991, p.520) points out that "The advent of psychotropic medication became a means to stabilise symptoms and facilitate independent living in the community". However the mentally ill could not be thrust out into the community from an institutional type setting without a net work of supports and it was case management that stepped in and provided this network that allowed a community living setting. In this way case management can provide a more normal environment, and hopefully a more comfortable and autonomous one. Thus the providers benefit because maintaining a huge central institution is far more expensive than funding a contract for a team of case managers.

Different providers can also be connected through the case manager each able to put in their own input and opinions, no longer is each separate agency working in a vacuum. We have seen how this can benefit the consumer, but it also benefits the providers because it means that they can each tailor their care so as not to supply redundant services and to thus be more efficient. Case managers themselves create a continuity of care, which means that any deviations of the health or welfare of their clients can be assessed and monitored before problems become unsolvable.

However, there are some negative aspects of the case management model. For clients it is that with forced deinstitutionalisation, case management may not sustain the needs of the acute consumers of health care, those for whom a community setting is unsafe. However with the hurried push to place these people in the cheaper option of the community, some people are left in an unfortunate state to their detriment.

The concept of fragmentation was discussed earlier, and in one sense case managers can provide a continuity of care, however this is in a psychosocial sense, and not in a geographical one. Because of the community setting, some health agencies may not be geographically situated within easy reach of all of the population, therefore transportation, especially for the disabled, is an issue. When all the services are located within one building, such as in a hospital, a pharmacy or physiotherapist may be just metres away, but in the community it may be an expensive taxi ride. Here we see how the consumer takes on the hidden costs of care.

Providers too can suffer at the hands of case management. With the advent of a free market ideology, along too comes the goal of profit. For example, the focus on competitiveness means that business skills can be just as important as nursing skills, or medical skills for example. Thus individual health providers must split their energies from practice to business in order to win contracts and financially succeed, or indeed to work at all (Wade, 1992).

To conclude, case management allows both consumers and providers flexibility and continuity of care. Consumers can reside within their familiar situation for the duration of their time of illness or disability. Case management has evolved as a less expensive option so it can be seen as being more efficient than institutionalisation.

References

- Litchfield M., Connor M., Eathorne T., Laws M., McCombie M., Smith S., (1994). Family nurse practice in a nurse case management scheme: An initiative for the New Zealand health reforms, report of the pilot study of the Wellington Professional Nurse Case Management Project. Wellington: Centre for Initiative in Nursing and Health Care.
- Moxley, D.P. (1989). The practice of case management. Newbury Park: Sage.
- Rothman, J. (1991). A model of case management: Toward empirically based practice. *Social Work* 36(6): 520-527.
- Wade, M.R. (1992). Community based nurse case managers: A model to meet New Zealand's changing health care needs. *Nursing Praxis in New Zealand* 7(3): 4-10.

Beginning Journeys - Volume 3

Infant Massage The Gift of Love

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"Love is the most important way to sustain a healthy happy life" Adams (1993, p.110).

We can never give our children enough love. According to Tracy in his seminars, we need to *"... pour buckets of love into our children on a constant basis ..."* (1988). Like having an intravenous line in place to give sustenance and care, we need a love line that is continually being supplied with endless love to nurture and sustain.

"Studies are now revealing that love is the most important stress reducing force known, just as the loss or lack of love is the most potent disease promoting force" (Adams, 1993).

This sharing of love cannot be explained more beautifully than as expressed by Mother Theresa.

"Spread love everywhere you go: first of all in your own house. Give love to your children, to your wife or husband, to the next door neighbour ... Let no-one ever come to you without leaving better and happier. Be the living expression of God's kindness; in your face, kindness in your eyes, kindness in your smile, kindness in your warm greeting." (As cited in Canfield & Hansen, 1993, p.3).

This spreading of love was the inspiration of a form of infant massage, caringly interpreted as *"... nurturing loving touch ..."* by McClure (1991) who developed a programme that would provide parents and caregivers with an opportunity to reach deeper levels of contact and caring with their babies.

Origins

During the 1970's while working in India, McClure contracted a severe illness and was nurtured back to health by the neighbourhood women who lovingly massaged and sang to her. She observed older children caring for younger children in the same hospital and was touched deeply with this experience. On her return journey to England she noticed a young mother massaging her baby in the dirt outside her shanty home. In what seemed to be extreme material poverty, something beautiful revealed itself as an expression of love and security, a gift beyond material wealth (McClure, 1991). Noticing young children playing happily, caring for each other and accepting responsibility without reservation, inspired McClure to establish a network of infant massage teachers. The intent to share worldwide and create an environment with parents in which child rearing formed deep bonds of encouragement and healing for both infant and parent. From small beginnings this inspiration eventually became the International Association of Infant Massage, set up to support parents in loving their infants and to open awareness that babies themselves deserved tenderness, respect, warmth and that they needed to be listened to (McClure, 1991).

Touch

Touch is a most subtle form of communication, conveying the intention of the giver. Research into the actual survival of the human infant who is touched lovingly; touched with the intent to hurt or not touched at all is well documented (Field, 1990). Leboyer (1977) describes how with a little kindness and intelligence we can eliminate fear of birth in the newborn with loving touch.

"... feeding babies with touches, giving food to their skins and their backs is just as important as filling their stomachs ..." (p.15)

A Brief Look at History

For centuries children were considered as nothing more than a smaller, weaker, less intelligent version of adulthood (Santrock, 1996). The *"... sweet simple and amusing nature of children ..."* (Papalia and Olds, 1995, p.24), as they were often considered, created negative attitudes which resulted in widespread abuse of children.

The first recorded information advising parents, on childrearing appeared in the sixteenth century, and was mostly written by physicians. These books were distinguished by a *"... complete lack of reliance on scientific truth ..."* (Papalia and Olds, 1995, p.24), with such advice as children being toilet trained at three weeks of age and binding arms to prevent thumb sucking.

Religion has had a strong influence on the understanding and acceptance of infancy which unfortunately was not always scientific or helpful. Certain dogmas cause people to believe infants were innately evil and to purge such evil the babies were subjected to enemas, plunged into cold water and beaten to purify their souls (McClure, 1991).

Around the 1800's the death rate of infants caused concern and psychological understanding became a form

of inquiry. However some psychologists such as William James stated that infants were unsensing, unresponsive, and unlearning organisms, and advised parents not to pamper and nurture them for fear of dependency. Other authorities encouraged mothers to wear masks to keep their babies germ free (Papalia and Olds, 1995, p.25).

By the nineteenth century the insights of the old ways and the desire to change were coming together and people of science were devising all manner of ways to study children. Most discoveries have been unearthed within the last twenty years with life-span psychologists uncovering capabilities of the infant almost every day. What is arising is the greater emphasis on bonding between parent and infant and the respect for the needs of the infant.

As we look back it is surprising that the human being survived at all and we can appreciate more that the pain carried over into adulthood often warrants mental and emotional healing through the plethora of counsellors now available and much needed.

Encouragingly, breakthroughs in understanding are more evident. In relation to childbirth itself, modern emphasis is being placed on natural ways of birthing. Emotional and physical abuse are less tolerated, and more parents are open to new and better ways of childrearing. Society as a whole is taking a greater role in being responsible for more healthy ways of being.

On another front, the medical world is more open to assessing the importance of maternal-infant bonding. Various developmental studies conducted in many universities around the world confirm this. Demonstrations show that infants whose mothers have difficulty touching, cuddling, or talking to their infants during the first few months of life are more likely to suffer from developmental growth delay. Scientific studies in understanding the newborn's sensory, motor and cognitive processes, have resulted in a new appreciation for the many cultural practices, which enhance child growth (Stovall, 1989).

What is infant massage and what makes this form so special?

Goethe (cited in McClure, 1996, p.1) say "... things which matter most should never be at the mercy of things which matter least ...". McClure attests from personal experience that when our ethics are in alignment with principles and passion, then life is rich, full and rewarding.

Before massage is attempted on an infant, the parent prepares him/herself, then gains acceptance from the infant by asking permission. Not only can the "aware" infant give signs of acceptance or non acceptance, the role of little valued intuition plays a major part. Mothers "know" their babies and understand more about them than is generally appreciated by the general public and health professionals. This process of "knowing" begins long before birth and can be developed by fathers and other caregivers once the baby is born. We can all bond, or "fall in love" as shared beautifully by a great spiritual teacher Paramahansa Yogananda.

"As a mother I drink the nectar of unconditional love from the soul cup of the tiny baby ... as an infant I drink the causeless love from the holy grail of maternal attraction ... as a father I drink reverential love from the spring of my child's heart" - (Yogananda, 1994).

It becomes increasingly easy to 'know' when the heart is open and ready to listen to the response of the infant. A bond begins to develop in a unique relationship between the two, that is specific and can endure throughout life. This bonding occurs with eye to eye contact, a biological synchrony of heart and mind becomes a reciprocal exchange. Loving touch is much more than the physical communication. It is the voice, the tone, it is a reaching into the human heart, and to describe it in intellectual terms is to lose the essence. If love is a verb, then joy is the feeling of peace and tranquillity that is shared between the infant and the caregiver. It is like a rhythmic dance of harmony transcending into bliss; a synchronicity of heart to heart that is healing and transforming for both.

In my experience it is the close experience of feeling 'God', the joy and unspeakable love that one would die for and is always present. I would not encroach into my adult children's lives nor will I live my life for them. They have their own, to experience and enjoy, yet I would unhesitatingly give up my life for each one of them at any time, so strong is the bond, a conviction echoed by many a mother. I asked my daughter (a midwife) what she thought of bonding. "Attraction" she replied, "a powerful attraction, when I held that wee baby up today and looked at him I felt this love and the urge to hold him close to me and cuddle him." "... It's falling in love" she said. Infant massage helps create this bond. In times of distress and adversity, sitting quietly giving ourselves permission and allowing love to permeate our being. Listening with an open heart and enjoying the process is "staying in love", and living each day in wisdom, love and acceptance (Personal communication, 1996).

How is infant massage performed?

The massage itself is a gentle warm communication taking into account the infant's small size and skin sensations and above all the willingness of the infant to continue. The strokes are long, slow and rhythmic. Relaxation is the key especially for the caregiver.

The strokes themselves are developed from several sources. They include Swedish therapeutic massage strokes, flowing towards the heart; Indian movements lovingly flowing away from the centre; some pulsating movements, reflexology and the final touch of containment holds. Therapeutic touch flowing into a rhythmic sequence completes the process. Any of the strokes, especially therapeutic touch can be used alone

according to the need. Many babies, including pre-term infants who may withdraw from actual massage, thrive with containment holds and therapeutic touch (Krieger, 1969).

The techniques are simple and easy to learn. It is having the wisdom, the knowledge and love that creates the flow. A background of beautiful music and lullabies set the scene.

Although there is still much work to be done to realise the vision of a universally caring society in which to raise compassionate caring human beings, the gift of love and security generated through infant massage will bring joyous opportunities to grow and prosper and enable the emergence of the love that is healing, in all human hearts.

References

- Adams, P. (1993). *Gesundheit*. Vermont: Healing Arts Press
- Canfield, J. & Hansen, M.V. (1993). *Chicken soup for the soul*. Florida: Health Communications Inc.
- Field, T. (1990). Alleviating stress in newborn infants in the intensive care unit. *Clinics in Perinatology* 17 (10): 1-9.
- Krieger, D. (1979). *The therapeutic touch - How to use your hands to help or to heal*. New York: Prentice Hall Press.
- Leboyer, F. (1987). *Loving Hands*. London: Collins.
- McClure, V. (1991). *Infant massage instructors manual*. New York: Australasian Chapter, ELMA.
- McClure, V. (1996). Tender nurturing touch. *The International Association of Infant Massage*,3(1): 3.
- Papalia, D. & Olds (1995). *Life span development* (2nd ed.). Sydney: McGraw Hill Book Company.
- Santrock, J.W. (1996). *Life span development* (6th ed.). Wisconsin: Brown & Benchmark.
- Stovall, D. (1989). Touch deprivation: Its significant impact on our children. *Massage Magazine*, 20: 937.
- Tracy, B. (1988). *Phoenix Seminars*. Auckland, NZ: Audiotape series.
- Yogananda, P. (1945). *Autobiography of a Yogi*. Los Angeles: Self-Realisation Fellowship.

Beginning Journeys - Volume 3

Exemplar: What Nursing Means to Me A Personal View

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For me, nursing is about caring, commitment, significant moments of happiness, moments of rewards and moments of helplessness. It is a lifestyle that I have chosen through no materialistic reason. I am driven to dedicate myself to this career through feelings so strong that I am at a loss to put into words my reasons, for the words are empty and meaningless compared to my feelings.

I have chosen needless to say, to dedicate myself to nursing, and in doing so I have committed my family, my husband, children and friends to accepting my choice which also infringes on their lives. As I embarked on this journey of furthering my nursing career, all these people have had to make sacrifices to encompass my need to help others.

Nursing is not a nine to five job to me, it is not about standing along from the medical profession and transferring blame for the hurt and tribulation that nursing has experienced. Nursing is not about focusing on the past, but to shifting the tides, moving into the future, continuing to strive tirelessly to improve and empower ourselves as nurses and those that we care for. Unity within our profession will strengthen our stance and validate the importance of our work and our significant contribution to health and the treatment of those who are ill.

What I value most in my practice, is recognising my role as one of assisting people, the deeper meaning in the word 'assisting' for me, is working in partnership with the individual and meeting the tapestry of needs incorporated in that person that has evolved throughout their life. I feel honoured to be the recipient of their trust and humbled to be a part of their care. I care for each person from a foundation of my own love for life and the joy of giving of myself to people, something that is intangible yet heartfelt.

I can't say that I hold any value in the title 'Nurse' for it is only a word of emptiness. The *values* lies in what that title allows me to accomplish, that for me is when the word 'Nurse' gains meaning. Nursing allows me to partake in a reciprocating circle of precious moments that range through a spectrum of spiritual, emotional and mental experiences, the giving and receiving. Rapport is paramount in promoting wellness, and it also puts a bounce in my stride! This allows me to erode barriers and for communication to begin, I value this chance to make a difference in someone's life.

Through the works of Benner, I see the need for me to be open to continued learning, as only through the progression from the novice to expert nurse will I enhance my good intentions. Through the realisation that personal and professional growth is a continuum from the presence to today to whom and what I will become in the future, I perceive this as the key to functioning not only as a person, but also as a caring, competent, intuitive nurse, intent on being the best that I can be.

Nurses are not recognised by this nation as the competent and significant contributors to health services that they are. I take responsibility and believe myself to be a silent partner in this attitude held by many. For how often have I spoken out about how powerless I have felt? Not very often. I will not be silent any more when someone puts down our profession, it will not be easy - nor do I expect it to be, but I *will* be accountable as I endeavour to make a small change in attitudes pertaining to nursing. I am proud to be a nurse, for me nursing is a way of life. It is integrated into what makes me *me*. I am only one pawn in this game but I intend to stand tall with my head held high, for whatever you want nursing to be - *can be*, but you have to be accountable and believe in yourself before others in the healthcare arena and clients will repute unquestionably nursing's powerful participation in healthcare - valuing the nursing profession the way nursing *should* be valued.

Beginning Journeys - Volume 3

To the Student Nurse

*Joanne Lilley, EN
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Students in a whole new world,
so scared of failure and rejection.
Yet the knowledge gained in only weeks,
is like the ultimate injection.

We are all here for our own reasons,
so badly wanting to succeed.
Nursing is now more than a science,
it's personal reflection and critical viewing of patients' needs.
We are a unique and dedicated group,
to the most amazing profession.
And you're not the first or the last,
in this infinite procession.

With goals set in positive foundations,
and a heart determined for success.
We'll get that start that means so much,
just strive to do your best!

Beginning Journeys - Volume 3

Research Conference Reports: Research and the New Tomorrow

14-15 July 1997 - Conference Report

Jackie Walker, RCpN, BA, Principal Academic Staff Member

This conference was hosted by Unitec, Institute of Technology, Auckland and the focus was on meeting the challenge of developing a research environment in tertiary education by rethinking the traditional approaches to research. About 120 delegates attended from Australia and New Zealand, with most coming from the Polytechnic sector or its Australian equivalent. The conference included keynote speakers, presentations, panellists and workshops giving a huge range of information and viewpoints. This report is my personal perspective of the sessions I attended.

The keynote speakers were Professor Mary O'Kane, Vice Chancellor of the University of Adelaide, and Professor Paul Ramsden, Director of Griffith University in Brisbane.

The key points of Mary's address included the need to be proactive in keeping abreast of current knowledge and research, to use technology, such as the Internet, to assist this, to form strategic alliances and develop collaborative research teams. She emphasised that in a competitive environment, funding strategies needed to embrace a broad spectrum of agencies and that good project management is crucial in collaborative research. Mary argued that tertiary education is in the "knowledge business" - whether transmitting, repackaging or generating inquiry or new knowledge. Research should be 'deglamourised' and made more accessible to staff and students and more emphasis placed on research for the public good.

Paul Ramsden spoke about leading and managing a research environment where the manager fosters a positive research climate with frequent communication, a firm but participative management style, good use of accessible resources and incentives and rewards for research performance and outcomes. Paul argued that traditional measures of research performance, such as journal or book publication and conference presentations, are limiting and other more diverse measures should be accepted. If a manager wants to increase individual research output then the departmental research activity levels must be increased. He gave some practical strategies for middle managers to increase research activity and these were:

1. *having credibility and leading by example*
2. *team building*
3. *performance management - recognising and rewarding outcomes*
4. *peer support networks*
5. *scholarship management plan*
6. *visitor programmes*
7. *workshops on thesis writing and publications*
8. *workshops on writing grant applications*
9. *research networks*

There was a wide range of speakers with differing perspectives across the presentations I attended and the following is a summary of some of the key themes.

1. Research is a valued activity not just for generating or reinterpreting knowledge, but for the generic skills of discernment, planning, analysis and communication that are developed.
2. Institutional policies, processes and structures are essential to support and foster research. A research office (as at the University of Western Sydney - Nepean campus) can offer a client-focussed service which supports and guides the researcher at every step of the research process, from proposal writing and grant application to publication of results. The office collects data on what and who is doing research for government agencies but this provides valuable data for the centre's management plan. This plan is revised annually in light of the data collected. Staff also help departments to develop their own research plans. The office administers funds which can be used for seeding grants, visiting scholars, staff development seminars/workshops.
3. Funding of research is problematic and will continue to be so in a contestable environment. Strategies which assist in the success of a grant application become crucial for an organisation to develop a 'track record'. The advantage of a research office is that the professional staff can offer expertise on how to write a successful application. The development of strategic alliances between institutions and

collaborative research teams can increase the likelihood of gaining funding. Combining experienced researchers with 'emerging' researchers is one strategy to increase the emerging researchers track record in grant application.

4. The lack of women researchers relates to the multiple roles that women take on and that their career (and gaining of post graduate qualifications) is often serendipitous rather than planned. Women often work in 'new' disciplines, including nursing, art and office technology, where there is no established research base. Many women have to focus on updating their qualifications to Masters or Doctoral level before they can concentrate on research. The need for curriculum development and professional development in, for example, nursing reduces the time available for research.

Women need to build their own networks, as they are usually excluded from male ones, and explore the use of mentors. Elizabeth Deane, University of Western Sydney, reported that mentoring may work well but it does not work when the senior women are overloaded with administration and the role of mentoring. She recommended effective collaboration between the teachers and research officers, flexible teaching loads, adequate research infrastructure and a women's register to develop networking.

5. Strategies which rewarded individual research performance and outcomes were crucial to supplement institutional strategies. People are tuned into the 'WII FM' frequency - 'What's In It For Me' and the positive and negative aspects of research need to be explored. In most institutions research is linked to promotion, which is an incentive for some. Teachers should access available services for their own development, including workshops and seminars.

Joint conference presentations or joint publications are strategies to encourage women to achieve research outcomes. Collaborative research has many strengths but a few pitfalls for the emerging researcher. Mary Panko (UNITEC) gave some useful advice on the need for a clear contract outlining the working arrangements, responsibilities and authorship at the start of the project.

Conclusion

This conference was extremely energising and gave me further insights into the complexities of developing a successful research environment. Examining the structures and strategies that the School of Nursing, Midwifery and Health Education uses to foster research shows that we have made a good beginning. The key areas that still need to be addressed are:

1. the need for a strategic research plan for the next 5 years
2. increased funding to undertake research
3. and the need for collaborative research with clinicians.

I am grateful for the financial support received from both the NZNO Education and Development fund and the School of Nursing, Midwifery and Health Education which assisted me to attend this conference.

Beginning Journeys - Volume 3

Conference Report: Research and the New Tomorrow

UNITEC Institute of Technology, Auckland, New Zealand, 14 - 15 July 1997

Cynthia Stokes, RGON, Adv DipN (CP), BA, M Ed (Dist) Nurse Educator, Christchurch Polytechnic

Conference Focus

The main focus of this conference was on the changing environment and the ways in which this impacts on the traditional approaches to research. The conference offered the opportunity to explore the issues that challenge research approaches at the global, institutional and individual level.

Format

Each day of the conference began with a Keynote Address (Professor Paul Ramsden and Professor Mary O'Kane) outlining current issues in research and education. This address was followed by discussion and questions involving the conference participants.

The remainder of each day was then taken up with parallel sessions, which were designed to be interactive, with ample opportunity for questioning and discussion with the presenter. The parallel sessions included presentations and workshops.

A booklet of abstracts was supplied to each delegate, plus proceedings on computer disks, and the option of the proceedings in hard copy was available.

Conference Proceedings

Presentations and workshops covered a wide range of topics. These focused mainly on the issues and challenges facing tertiary institutions and teachers who are involved in research. The choice was extensive, with a total of 34 different options being offered.

Brief Synopsis of a selection of the sessions attended

Professor Mary O'Kane (Keynote Speaker) (Vice-Chancellor, University of Adelaide)

This session elaborated on the speaker's own views of Research in the New Tomorrow:

- Role of research in a global sense - need to know one's own field and what is going on in it. Form alliances within own institution and around the world. Become an aggressive user of the internet - use facilities from other places via internet, and can also do collaborative research via internet. Funding - research is cheap via internet, but expensive to keep up with rest of the world.
- Be creative with funding - (strong advocate of industry funding it), Government, other institutions. This however can create issues like; ownership, control, conflict, cultural elements.
- Research training - attract post-doctoral as well as PhD level.
- Look at people's potential to do research, not only at those who have a track record.
- New knowledge - where is it being created? An important issue - some places do not value new knowledge or new researchers. Heavy reliance on "riding on the coat-tails" of those doing it.
- Knowledge as a commodity - it can generate wealth. Institutions need to capture key people to do research in a particular field.
- Funders overall need to take a gamble on which research will really push the boundaries of what is already known!!

Andrew Codling: "Staff views on the right research direction"

(Director - Research and Development, UNITEC)

- This presentation commented on the process and findings of a study conducted at UNITEC, which helped focus the direction for research within the institution.
- Results:
- Teaching is the priority - research should support teaching. Do not want to emulate a formal university!!
- Applied research should be the focus (but ongoing debate on this aspect).

- Debate also over the definition of Creative Research (NZQA)
- Important to sort out how staff research is to be measured. How to establish credibility and quality of the outcomes? Forms of recognition for doing research?
- Funding is a problem.
- Who will/how will research be coordinated?

Mary Panko - Collaborative Staff Research (Programme Leader for tutor development, the Graduate Diploma in Higher Education UNITEC)

This presentation examined the collaborative process within a research team, the benefits and pitfalls of collaborative research, and mechanisms to improve effectiveness.

Definition of collaborative research and who might be involved - same discipline, faculty or another institutions (also the Internet and e-mail are options).

Planning the joint-venture: academic and personal attributes of researchers needs to be analysed (richness of experience, diversity of expertise, potential conflicts and problems).

The Process - a Flow Chart directed the discussion, which focused on:

- team selection
- team leadership
- defining the question
- selection of methodology
- revisiting team membership
- developing agreements between members
- conducting the research
- writing up
- presenting publications

Benefits of conducting collaborative research:

- new learning and skills
- interpersonal skill development
- fostering of team process
- open debate and trust in abilities of others
- greater chance of acceptance of work (small lit. review included)
- Pitfalls:
- emotional aspects of collegial misunderstanding
- feeling overwhelmed by others
- potential exposure as a "failure"
- potentially destructive agreements
- misunderstanding about the research focus or final report

Conclusion:

- academic benefits are huge
- importance of identifying pitfalls before they occur
- motivating and supportive of "new" researcher

Key Issues raised at the Conference

- Funding is a big and ongoing issue.
- Need for collaborative not competitive research approaches
- Need for creative ways of doing research
- Need to develop an organisational structure to support the research climate

- The positive relationship between research and teaching
- Ways of fostering and supporting the "new" researcher
- Reliable means of measuring research outputs
- De-mything the "academic and intellectual" nature of research
- Valuing the variety of ways in which research can be done

Summary

I gained a lot from attending this conference, both as a researcher and a teacher of research. I learnt some new strategies I could incorporate into my teaching about research to students.

The opportunity to discuss concerns and issues involved in doing research as a nurse with others was valuable. Although there were not many nurses attending the conference, those of us who were there, found time within the busy timetable to engage in discussion on research in nursing and nursing research. There were two presentations from nurses (Professor Judy Lumby and Teachers and Students from UNITEC Bachelor of Nursing course) which I found both affirming and applicable to the role of research within the nursing profession.

Attendance at the conference confirmed to me that the place of research in the nursing profession has similar issues and challenges as those found in most professions and disciplines. It also confirmed that the research focus in the Bachelor of Nursing programme is appropriate to teaching and nursing, and is keeping pace with new developments in and approaches to research.

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Beginning Journeys - Volume 3

NZNO Research Conference 1996

Ruth Densem, RGON, Transition to Degree Student and Practitioner

It was an exciting conclusion to my Bachelor of Nursing finding that I was to be one of two fortunate students offered sponsorship from the School of Nursing, Midwifery and Health Education to attend this research conference being held at Massey University late in November.

There was enthusiasm on that opening day of the conference. The chosen theme "Under New Management: Nursing Takes Hold of the Future", and Diana Gunn, (NZNO Professional Nurse Adviser), gave the opening address, "Have we got a Future to take hold of?" she asked. "What is the nursing role and what have we done with the humanistic element", explaining that the oral tradition of nurses sharing verbally, inhibits nursing documentation. Full documentation of, for instance progress notes, is essential, and it should be holistic nursing documentation (we are still often documenting only in a biomedical mode). She urged us to "make visible the holistic and humanistic aspects of nursing practice by documentation and discussion".

Phillip Darbyshire, the keynote speaker, took the podium. His opening question was, "Is our glass half-full or half-empty?" He himself has an optimistic view of the future of nursing, explaining that the alternative of nihilism and despair holds no value! He said that this may well be the best of times and the worst of times for nursing, and that "all jobs are up for grabs and old boundaries are disappearing". Things nowadays are not for "keeps", and nothing in health care can be taken for granted. Everything has to be justified, which can appear to be a down side, but it serves us a useful purpose in nursing because we can show that what we are doing is important and valuable.

If we think our cup is half empty, and wait for a wonderful time to come along, we will be waiting a long time. We must see that our cup is half full and twist the kaleidoscope to see new perspectives. He later spoke about Research, and the concern some have that there is no money available. His comment was, "If you're streetwise about how you sell your research proposal, there is money available". He continued to plead that we must encourage research to "be done on the factory floor" (ie, on the wards etc), and not just in the universities, after which it often sits on the library shelves gathering dust. We must promote clinical research involving clinicians and researchers together, but also remembering that research itself does not change practice, whereas practitioners do.

He referred to nursing's four horses of the apocalypse; What are we doing, Why are we doing it that way, How can we do it better, and What beneficial effects is it having on peoples' health? In facing up to these four horsemen, he said we must not take these following options; Hope it will all go away!, Do nothing!, Hope someone else will deal with it! "Adapt" rather than "shape", and Wait until we get more staff, money, time, resources or support! Nurses must situate themselves to take full advantage of any opportunities offered in such turbulent times and the present. "If there is a parade out there, we had better make sure that we are at the front of it". Phillip Darbyshire was certainly an inspiring and appealing speaker.

The conference was jammed with talented, informative and interesting speakers over the three days, who gave us a broad perspective on nursing research as it affects practice and education. I learned so much from them and from networking with others.

The conference dinner was an enjoyable event not easily forgotten. Colleen Singleton, the Chief Executive Director of the Nursing Council, was the guest speaker, and she spoke about acclaiming affirmative pathways for nurses.

I would like to conclude by offering my sincere thanks to the School of Nursing, Midwifery and Health Education for generously sponsoring me to enable my attendance at the conference. It was a valuable opportunity to further my knowledge and it also helped to inspire me sufficiently to undertake postgraduate research studies this year.

Beginning Journeys - Volume 3

NZNO National Nursing Research Conference Report

29 November - 1 December 1996

Christine Waterman RGON, BN, Cert AdvTchg Practitioner

'Under New Management: Nursing takes hold of its Future'

This was the 23rd anniversary nursing research conference, it was "designed as a learning exchange for nurses from every sphere of nursing; from practice, management, education and research." Participants and presenters brought a broad representation of this spectrum, enabling a rich and varied conference programme.

The theme for day one '*Opportunities and Creative Responses*' was opened by Dianna Gunn, NZNO Professional Nurse Advisor and National Coordinator. Gunn's opening address asked 'Have we got a future to take hold of?' This paper offered affirmation of a nursing future, through Gunn sharing her experience of innovative practice in her previous post. The 'feelings' of staff and patients were incorporated in nursing documentation where Ms Gunn worked, this created a more descriptive holistic style of nursing documentation. Documentation was a key issue in this presentation, her experience demonstrated this change in documentation style resulted in greater collaborative relationships within the multidisciplinary team through shared understanding.

This led to a lively debate from the floor, with concerns about ethics, privacy and the need to define the purpose of documentation. This presentation set the tone of the conference. A strong caring ethic pervaded presentations, and examples of nursing taking hold of the future through creating opportunities in health care. As Gunn said, "We can only be responsible for what we create."

Philip Darbyshire, the keynote speaker of the first day made a comment: "Researchers do not change practice practitioners do." This was reflected in the presentations over the next two days. Clinical practitioners from psychiatric, paediatric, rural, community, management, surgical and medical realms of nursing practice ably demonstrated this. Papers presented demonstrated change brought about by practitioners using research as a tool to find best practice.

Almost a year later, I continue to draw upon the enthusiasm and knowledge this conference imbued in me. Almost every day I find myself in discussion with clinical staff about their practise and patient care. What better forum to discuss what research has to offer nursing? There is still a strong feeling of antagonism towards research, or the notion of "research is not for me; I just want to nurse". To those who might be feeling research is a drag or not related to clinical practice, I offer the words of C.F. Kettering:

"Research is a high top word that scares a lot of people it needn't. It is nothing but a state of mind, a friendly welcoming attitude towards change. It is a problem solving mind as contrasted with the let-well-alone mind. It is the composer mind instead of the fiddler mind; it is the tomorrow mind instead of the yesterday mind."

I wish to sincerely thank the Polytechnic Research Committee for the opportunity to attend this conference. I feel sure the ramifications are still growing. Thank you.