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EDITORIAL

TELLING IT LIKE IT IS

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The habit of writing about our work is something we New Zealand nurses are developing slowly but steadily. In a small country such as ours, and in a discipline with a strong oral tradition, it can seem a rather daunting task to put pen to paper (or finger to keyboard) to record things we may believe others already know. I am not innocent of this reluctance to write myself - so I am some kind of expert! - but I am firmly of the opinion that we need to write more. There are several reasons why.

Firstly, and most importantly, other people are interested in what you have to say. For an author it is empowering to tell others about what you have achieved, to share your insights about nursing practice, and to help others understand the world the way you see it. It is also affirming to see your own ideas in print and to claim ownership of those ideas that you have been able to contribute to the professional domain. Readers find it exciting to learn about other people's work, to debate these ideas, to discuss the new insights that arise, and to think how what we have learned might contribute to our own practice. While talking about practice is useful in the immediate sense, writing lasts longer, can be referred back to, and eventually builds a body of knowledge that documents the progress of the discipline (in a historical sense as well as clinically and theoretically).

I think one of the reasons nurses are sometimes reticent about writing is humility. The task sometimes looks too hard and many of the articles we read in the academic environment seem inaccessible. We may ask ourselves "Who wants to write like that and who am I to write anyway?" I would answer that all nurses have a contribution of some kind to make to the discipline, and add that good writing does not put people off reading. Perhaps the best trick I have learned about writing is to picture your audience and then write specifically for them. Imagine you are writing for your colleagues, your students, your friends. The people you want to reach are people just like you. Here is where our Kiwi talent for honesty and courteous directness becomes useful. Good writing is straightforward and easy to read. While there are conventions for things like referencing don't let these get in the way of a good argument, a clear description or a contentious argument.

As to what to write, what interests your reader will be what interests you. What is new in your field? What troubles you? What have you learned? What work have you done that you can share with others? Remember that your contribution is likely to be a wider audience than simply nurses. Nurses have a great deal to share with the multidisciplinary health team. Think about what you have to say. Picture your audience. Then write it down. The profession needs your contribution. Just tell it like it is.

Aesthetic knowing and the use of arts in nursing

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Introduction

In this article I will consider aesthetic knowing and the use of arts in nursing. Aesthetics, the art of nursing, is an integral part of nursing practice. The aesthetic pattern has been increasingly valued as nursing has recognised that each of Carper's four fundamental patterns of knowing has contributed to nursing knowledge. Concepts that pertain to the art of nursing will be identified. An underlying moral sense is articulated and the interrelationship of the moral sense and the art of nursing is discussed. The contribution of the mediums of non fiction, fiction and poetry to the aesthetic way of knowing is also discussed. The relevance of the aesthetic way of knowing to nursing is considered with the aim of identifying uses of the arts in nursing education, practice and research.

Carper's four fundamental patterns of knowing

Carper (1986) analysed 11 years of formal nursing knowledge identified in textbooks and nursing journals. She described four fundamental ways through which nurses have gained knowledge. The four patterns are: empirics, the science of knowing; ethics, the moral component of nurses' knowledge; personal knowing; and aesthetics, the art of nursing. Carper identified each way of knowing as an important component of nursing knowledge. Each is separate, yet interdependent. Carper claimed ethics, aesthetics and personal knowing to be valid and important ways of knowing in nursing. She acknowledged the importance of using all ways of knowing in practice.

Empirical knowledge has been highly valued and has dominated scholarly nursing knowledge (Carper, 1986). However empirical knowledge does not provide well for the humanness about which nursing is concerned. Ethics, personal knowing and aesthetics all relate to humanity and identify and address crucial aspects of nursing practice. Each pattern contributes separately to knowledge, yet is interrelated with other patterns. An example of this interdependence is the way in which the moral sense of nursing influences the aesthetic and personal ways of knowing. Bishop and Scudder (1990) identify the first moral requirement of a nurse to be excellent in practice. This obligation provides a philosophical position which affects the ways in which nurses gain knowledge. The responsibility for nurses to act in the client's best interest is an integral part of nursing and is expected by society. The application of the knowledge gained through all ways of knowing has excellence in practice as the moral standard with which nurses and clients can judge the effectiveness of nursing.

Valuing the aesthetic pattern of knowing

Aesthetics, the art of knowing, has been an integral part of nursing practice since Florence Nightingale wrote notes on what she believed nursing to be (Nightingale, 1969). The apprenticeship model, present in New Zealand nursing training for the first 75 years of the twentieth century, has facilitated the art of nursing being passed from nurse to nurse. In the hierarchical system however, nurses have valued knowledge from those in superior positions, rather than their own knowledge. As empirical knowledge has been valued highly and has dominated as a way of knowing, aesthetic

knowing has been valued less. In the past the aesthetic way of knowing has been perceived by nurses to be subjective and unreliable.

Weidenbach (1963) described nursing as a helping art. She encouraged nurses to value their thoughts and feelings. She believed this would enhance their nursing practice and positively affect nurses self esteem. She valued the aesthetic way of knowing, and encouraged other nurses to value this pattern. Carper (1986) clearly articulated that nurses use all four patterns of knowing in their practice. She described each pattern, and identified interpersonal aspects of the aesthetic way of knowing. Benner (1984) surfaced some of the knowledge found and used in nursing practice. She described expert nurses' use of all ways of knowing in their practice. The creativity inherent in excellent practice is evident in her descriptions. Uncovering these aspects has encouraged awareness of them as well as the valuing of them.

Johnson (1994) reviewed nursing literature relevant to aesthetics. She identified five predominant conceptualisations of nursing art. They are the ability of the nurse to establish a meaningful connection with the client, grasp meaning in client encounters, skilfully perform nursing activities, rationally determine an appropriate course of action and morally conduct his or her practice. Johnson believed that nurses have described the art of nursing, but have talked past one another rather than to each other. Therefore the way in which aesthetics has developed lacks focus and is diverse.

The art of nursing

The art of nursing is used to describe many aspects of nursing. Each nurse will perform many nursing activities many times each day. The art of nursing is expressed through the creativity of the nurse, and accounts for some of the differences in performance. The uniqueness of each nurse and each client combination is such that no two situations are ever exactly the same. The artistic application of all ways of knowing provides the uniqueness of quality individual client care.

There is an underlying moral component of excellence in practice, identified by Bishop and Scudder (1990). This excellence is based on nursing values. Watson (1985) posed the values of tenderness, kindness, caring and concern for others, as values nurses practicing the art of nursing need to adhere to. The moral basis acts as the motivating force for quality nursing care. The aesthetic way of knowing is thus grounded in ethical knowing. The nurse practicing the art of nursing strives to connect with the client, find meaning in the client situation, act artistically and acknowledge the uniqueness of the individual.

Connecting with the client in a meaningful way

Carper (1986) claimed empathy to be an important mode in the aesthetic way of knowing. When empathising "one gains knowledge of an other person's singular particular felt experience through empathic acquaintance" (p. 255). Through empathy the nurse increases her or his sensitivities and abilities to provide a wider range of nursing cares. This occurs as the nurse's perception of reality broadens through exposure to the realities of others. The nursing care must include "balance, rhythm, proportion and unity of what is done in relation to the dynamic integration and articulation of the whole" (p. 255). Approaching the client holistically and having an overview in order to perceive the total picture are important aspects of knowing how to provide quality care for each client.

Empathy, as a way of obtaining knowledge in practice, is by means other than touch, sight and hearing (Chinn & Kramer, 1991). It is felt and experienced. It involves knowledge of the moment, of the time of the actual communication. The criteria for empathy have been established as this concept has been defined and distinguished from closely related concepts such as sympathy (Chinn & Kramer, 1991). Each empathetic moment will be unique and specific to that moment.

The moral sense of nursing underlying empathy is caring. The obligation to care provides for a willingness to connect in a meaningful way. Caring is encouraged by theorists such as Watson (1985) and Leininger (1981). It is a complex concept with surrounding moral issues.

Establishing a meaningful connection is described by Chinn and Kramer (1995) as engaging. This is a creative process. It includes being present and making a commitment to the client. The nurse who makes this commitment is described as being an authentic nurse (Bishop & Scudder, 1990). Bishop and Scudder claim the authentic nurse *is* a nurse, whilst the inauthentic nurse plays a role of being a nurse. The nurse has a moral obligation to be an authentic nurse.

Grasping the meaning of the experience for the client

Johnson (1994) described the need for the nurse to grasp meaning in each client situation, as each situation is complex. Grasping meaning is sensed rather than consciously intellectualised. It involves understanding the whole of the situation, immediately understanding the meaning within. Some authors refer to this as intuition (Benner, 1984; Paterson & Zderad, 1988). Benner (1984) describes the acquisition of skills by expert nurses, by describing their knowledge bases and the skills used to apply their knowledge in practice situations. Expert nurses use intuition instead of conscious analysis, in situations in which they have prior experience (Benner, 1984). The intuitive grasp of the situation is based in repeated exposures to experiences.

Leners (1993) suggests that novice nurses possess intuition but are not able to recognise patterns because they have not had repeated exposures. Confidence in intuition develops with experience. Leners (1993, p. 228) describes the risks associated with intuitive knowing as “putting yourself on the line”. The risk involved is the loss of credibility. The subjective nature of knowing that is involved in intuition is difficult to put into words. It may be intuited from the look of the client. Objective data may not be present. The only way the expert nurse may know in a particular situation is through intuition. Credibility versus the moral commitment to act in the client’s best interest may be weighed up by the nurse in order to make a decision about acting on the intuitive knowledge. Leners cautions against intuition being a duty of the nurse. If intuition is not present the nurse has a responsibility to look for meaning for the client in the experience. This may be a conscious intellectual activity instead of the unconscious intuition of the expert. Benner and Tanner (1987) claim that intuitive knowledge and analytic reasoning often combine effectively.

Artistry in nursing actions

The range of nursing actions available to the nurse extends with experience. Expert nurses are able to unconsciously select from an expensive repertoire of actions (Benner & Wrubel, 1989). Nursing actions include the manual dexterity necessary for technical skills, as well as the artistry of the application of the skill. As the nurse develops

expertise the focus shifts from the dexterity required to complete an action, to the creativity of the action itself. Skilled know how is applied (Benner & Tanner, 1987). The range of actions available to the nurse extends as alternative possibilities are experienced.

Chinn and Kramer (1995) use the term 'envisioning' to describe the ability to imagine possibilities. The means and the end, the process and the product are both thought of as the nurse's search for other possibilities. The client experience and the predicted outcomes are monitored and creatively applied to the situation. The art/act is the actual doing. Gendron (1994) poses an analogy of a tapestry to explore nursing activities. Her warp consists of the constraints of the nursing context, such as resource limitations and agency policies. The knowledge and skills required for holistic nursing care are also of the warp. Her weft consists of the unique and individual balance, harmony, rhythm and unity of the nursing actions. The combination of weft and warp provides holistic synchronised care, utilising the aesthetic and other ways of knowing to promote the art of nursing in creatively caring for the client.

Bishop and Scudder (1990) identify a moral tension between the routine procedures which may be repeated many times in nursing practice and the unique application of personal care for the client. This creates a moral dilemma which is founded in the expectation of 'giving good care'. The nurse has legal, ethical and professional boundaries which delineate the scope of his or her actions. Despite these boundaries the decisions nurses make in order to act may be complex and ill defined.

Expression of the art of nursing in art forms

Non fiction, fiction and poetry will be addressed.

Firstly non fiction. The use of non fiction in nursing has been encouraged during the 1980s and 1990s. As research methodologies applied in nursing have broadened, from an empirical approach and scientific methodology to include an interpretive approach of phenomenology and lived experiences, nurses have been encouraged to write about their experiences. Benner (1984) clearly articulates knowledge which is an integral aspect of nursing practice. This knowledge links one nurse to another.

The use of narrative to tell the story illustrated the work of the nurse and the art of nursing. Exemplars may be excellent descriptions of the art of nursing in practice. The nurse retrospectively writes about her impressions of an event or an episode of care. Story has been proposed as a method of linking nursing practice, ontology and epistemology (Boykin & Schoenhofer, 1991). The story is a recreation of the practice event, and illuminates the happenings. The nursing knowledge within the event is visible through the interpretation of the story. This allows for understanding and review as nurses share meaning and gain insights. Critique is also possible and this allows for an extension of knowledge, as different perspectives are discussed. Nursing knowledge is shared, including the art of nursing. The meaning within the story may be felt in a way which is not possible to describe in words. The knowledge gained is unique. It becomes possible to change practice through reflection on experiences and the application of creativity.

Secondly, fiction. Fiction is a medium for enhancing the aesthetic way of knowing (Sorrell, 1994). The knowledge within the story may be accessible through words and known to the reader through feelings. There is no universal truth to be known, rather a personal search for understanding (Sorrell, 1994). The aim of narrative fiction is

exploration. Reading fiction creates an understanding that words are ambiguous and convey many meanings (Vezeau, 1994). The sense of uncertainty which arises from the ambiguities can be appreciated. Fiction is helpful in assisting nurses to understand an experience from another person's perspective.

Thirdly, poetry. Writing and reading poetry is expressive. The insights which are able to be created, expressed and shared through poetry are often profound. They may be unable to be shared through stories in the same way. The ability to succinctly and creatively transfer meaning through selected combinations of words is highly creative. Watson (1994) suggests that poetry aims to please and to instruct and as such involves truth. Whilst it is not possible to know another's experience, it is possible to search for meaning by reflecting on the experience and the meaning. An inner self evident truth is possible (Watson, 1994).

Creating aesthetic knowing

There is a wide scope for the use of aesthetic knowing and the arts in nursing education, practice and research. The changing health environment in which nursing takes place ensures that nursing is ever evolving. There is a need for ongoing searching for truth or meaning. Bevis (1988) identified that the types of learning required for education, rather than training, include syntactical learning inclusive of the artistry involved in the art of nursing. At this level the learner sees wholes, provides unique client care using models from practice and thinks creatively to find insights and meanings.

The use of the arts to stimulate learning is yet to be fully explored in nursing. Watson (1988) believed in fostering creativity and perhaps developing courses using art forms as ways of subjectively examining health and illness. Parker (1992) explored the aesthetic meaning of 'presence' in nursing practice. She explored "the meaning of the practice of art to the practice of the nurse artist' (p. 28). She found similarities as both require creativity, dedication and honesty. The practice of art for the nurse artist involves searching and expressing experiences and feelings. The practice of nursing for the nurse artist is unique and creative (Parker, 1992).

Aesthetics unifies other ways of knowing so that the personal, empirical and ethical ways of knowing are creatively applied to the client. Reflection on practice enables other possibilities to be considered. There is the potential to apply art mediums as ways of developing knowledge. Gortner (1986) encouraged the use of multiple paradigms including analytic and humanistic. The aesthetic way of knowing may be applied to other ways of knowing to perceive possibilities and to identify relevant areas of interest. Creativity does not follow previously defined paths. It is not clear whether studying the arts leads to increased creativity and whether this would translate in to a positive effect on client experience. The role of the use of the arts in education has therefore not been clearly established.

Conclusion

This article has described aesthetic ways of knowing. Meaningful connections to others, grasping meaning in the client's experience, and the artistry within nursing have been discussed. The art mediums of non fiction, fiction and poetry have been discussed in relation to the ways of knowing each sustains. Non fiction and fiction narrative encourage the ability to 'see through others eyes' and the importance of this to nursing has been described.

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Literature Review: Cultural Safety

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Introduction

Nursing education in New Zealand began its association with cultural safety in the early 1990's (Papps & Ramsden, 1996). The introduction of the concept into the nursing educational infrastructure was not easy or harmonious, and was surrounded by controversy and debate. However its place in nursing is integral and needed in order to produce nurses capable of delivering safe care in any cultural environment. A literature review was conducted into cultural safety, utilizing Cumulative Index of Nursing and Allied Health Literature (Cinahl) and ProQuest databases, to ascertain the current status of knowledge in this topic. The literature reviewed was then divided into content themes. While many themes existed only two shall be presented, 'The term cultural safety: defining and understanding it' and 'The use of transcultural nursing theory in New Zealand'. These themes were selected as they represent two of the most prominent and reoccurring aspects of cultural safety within the literature.

The term cultural safety: defining and understanding it

Chapman (1993) and Kearns and Dyck (1996) indicate that Maori (both nurses and non-nurses) coined the term cultural safety in 1988. Polaschek (1998), Ellison-Loschmann (2001) and Wood and Schwass (1993) all point out that the term cultural safety initially was difficult to define. Polaschek (p.453) states "a period with an acknowledged lack of definition" followed the 1988 conception. Ellison-Loschmann and Wood and Schwass suggest this lag in the construction of a definition occurred as defining just what the concept encompassed presented a challenge. Chapman (1993) and the Nursing Council of New Zealand [NCNZ] (1996) believe that this challenge arose because the cultural safety concept was based in dealing with the realm of the intangibles of people realities, such as attitude. Polaschek takes a slightly different stance, citing the difficulty as stemming from the need for the definition to attempt to cover a multitude of interrelated ideas.

A review of the literature revealed that a singular definition for cultural safety does not exist. Many differing definitions prevail, which could be due, as Cooney (1994, p.6) suggest to the fact that "the definition of cultural safety has not been finalized". However all definitions appear to share the same core essence, that users of a health service needed to feel safe in relation to their cultural identity, and not be threatened by these interactions. It is acknowledged that nurses could avert this problem through practices that impart recognition, respect and nurturing of the client's unique cultural identity (Benham, 2001; Bunker, 2001; Polaschek, 1998; Wood & Schwass, 1993).

A more comprehensive definition was inducted by NCNZ in 1992, which Ellison-Loschmann (2001, p.12) cites as being "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on her/his own cultural identity and recognizes the impact of the nurses culture on her/his own nursing practice". Although Polaschek (1998) criticizes the ambiguity that she perceives

as emanating from these definitions, Chapman (1993) argues that no rigid definition can be achieved as cultural safety incorporates dimensions, which unlike physical or legal safety, are less measurable.

The term cultural safety was to endure a climate of confusion, which saw misinterpretation of what it meant (Benham, 2001). Chapman (1993) agreed when acknowledging that little true understanding existed amongst the public. Ramsden (2001a) points out that the popular definition of culture held by the majority of people, which sees culture as solely ethnicity, led to the simplistic notion that cultural safety was about Maori culture. Benham affirms this by reiterating the same point. In order to understand the term correctly, Papps and Ramsden (1996) suggest investigating what each word means.

Culture must be used in its broadest sense and includes many elements, such as class, age, sexual orientation and religion. Ellison-Loschmann (2001) indicates that nursing literature should not confine culture to ethnicity. NCNZ (1996) agrees and outlines that culture represents all aspects of difference from the norms of nurses, both on a personal and professional level. Both Ellison-Loschmann and Papps and Ramsden (1996) consider that the word safety is linked to nursing language and practice, with the latter authors defining safety as “nursing action to protect and/or reduce risk to client and community from hazards to health and well being” (p.493).

The term cultural safety was created by Maori. A definition to accompany this term was initially absent due to the challenging nature of the concept behind it. Whilst many definitions exist they all share the same core essence. Misinterpretation of the term's meaning has occurred, primarily due to the narrow definition of culture that people have held. To understand the term, culture must be seen as incorporating all aspects of difference from the norms of nurses, at both a personal and professional level. Safety must be understood as nursing actions within practice that protect/reduce risk to clients.

The use of transcultural nursing theory in New Zealand

Cultural safety literature generally argues that Leininger's (1984) transcultural theory is not appropriate for New Zealand nursing (Author unknown, 2000; Ellison-Loschmann, 2001; Cooney, 1994; Coup, 1996; NCNZ, 1996; Papps & Ramsden, 1996; Smith, 1997). Leininger (1997) counters this by suggesting that New Zealand nurses do not understand her theory. If they did they would see that it is appropriate. Smith refutes this when offering the opinion that Leininger is not fully informed about the context of the New Zealand situation. Opposition to transcultural nursing appears to stem from its perceived inability to address the unique issues within the New Zealand context (Cooney; Coup). Moreover Cooney suggests that transcultural nursing and cultural safety do share commonalties however Papps and Ramsden (1996) stress they are not the same concept.

Transcultural nursing contends that by studying the rituals and customs of people from different cultures and creating a knowledge base of ethnic specific knowledge, nurses will be able to effectively care for clients from different cultures (NCNZ, 1996; Papps & Ramsden, 1996). Polaschek (1998) elaborates that transcultural nursing identifies the learning of key facts about a culture as enabling adequate service provision to all members of that culture. This, the NCNZ argues, is not sufficient, as people are diverse and learning these aspects may reinforce stereotypes and preconceived ideas.

Coup (1996, p.10) suggests that the utilization of transcultural nursing in New Zealand would be “demeaning and disempowering for Maori”. Papps and Ramsden (1996, p.495) see the use of transcultural nursing as an example of “continuing colonial behaviour, which acceptance of the treaty endeavours to address”. Smith (1997), Cooney (1994), and Coup further argue that Leininger is a member of the dominant culture and her theory was therefore developed from this position – the perspective of an observer. Transcultural nursing sees nurses as representing the normal culture and that all others are “exotic”, thus power is maintained within the dominant culture. According to Cooney while transcultural theory requires nurses to examine their own cultural beliefs and values, it would not, like cultural safety, require the nurse to gain knowledge as to how this impacts upon the client and dictates power relations. Learning about ethnicities is not what is needed. Cultural safety is about understanding the power dynamics within the relationship between nurse and client, so that power is transferred to the client (Author unknown, 2000).

It appears that transcultural nursing is widely considered as inappropriate for New Zealand nursing by New Zealand nurses. Transcultural nursing theory is opposed on the basis that it is not transferable to the New Zealand environment because of its inability to address important issues that exist within New Zealand.

Current status/future directions

It appears from the literature that a detailed knowledge surrounding the concept of cultural safety, its origins, development and relationship with nursing exists. Despite early controversy over the inclusion of cultural safety in nursing education, it is now firmly established within it. It appears that nurses and student’s attitudes towards the concept are generally positive and supportive (Ramsden, 1993; Saxton, 1995). Areas other than nursing are also starting to ponder the benefits of inclusion of the concept (Kearns, 1997), and in the future cultural safety might extend across the educational processes of all health professionals. Polaschek (1998) argues that cultural safety in the future needs to broaden its aims to include addressing the societal as well as the personal dimensions, as enlightened nurses cannot make much difference in any monocultural institution alone. Large-scale change is needed within the health care system and to create this, cultural safety concepts need to be extended towards redesigning social structures. Papps and Ramsden (1996, p.374) affirm this notion stating that consideration needs to be given to extending the concept to “health and social policy more generally”.

Currently cultural safety theory is little known or used outside New Zealand, but this is changing. Coup (1996) and Cooney (1994) identify that interest from other countries is starting to grow and it is suggested that cultural safety could be useful to the global community (Ramsden, 2001b). What appears not to be known at this stage is just how effective cultural safety really is. Papps and Ramsden (1996) explain that cultural safety is a relatively new concept, which still has to be fully evaluated and researched. A gap in the literature appears to be present relating to the consumer’s experience of cultural safety, which Papps and Ramsden express needs investigation, as consumers are seen as the real judges of the effectiveness of cultural safety.

Conclusion

This review of cultural safety literature has revealed that Maori, including nurses, created the term cultural safety. Initially a definition of this term was difficult to construct due to the challenging nature of the concept it represented. Currently there is an array of definitions, which essentially all share the same core essence. The misinterpretation the term endured in its genesis was found to have been primarily due to the narrow definition of culture that people held.

It was found that in order to understand the term cultural safety correctly within the nursing context, culture must be seen as incorporating all aspects of difference, and safety must be understood as nursing practice which reduces risk to clients. It appears that while the idea of nurses utilizing transcultural nursing theory in New Zealand has been considered, it has been seen as inappropriate. This theory has been opposed on the basis that is not transferable to the New Zealand environment because of its inability to address important issues existing within this country.

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Cultural safety at risk in the nursing care of a mentally ill patient in a general surgical ward: A perspective from clinical practice

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Introduction

If culture can be defined as “the beliefs and practices common to any particular group of people” (Nursing Council of New Zealand, 2002, p. 3) then one of the keys to providing culturally safe care is for nurses to recognise they are bearers of their own culture (Nursing Council of New Zealand). This paper will examine the cultural risk associated with the nursing care of a woman called B. The details pertaining to this case come from the author’s observations of and interactions with B. Although this was not discussed with B, it is the author’s contention that her care was compromised by culturally unsafe nursing practice. The existence of a barely documented yet evident mental illness and the negative attitudes of several nurses who failed to address it gave the author concerns about B’s safety on the ward. Critical social theory and cultural safety knowledge will be used to explore the events, the ethics, and the power relationships associated with the care of an ‘atypical’ patient in a general surgical ward. Finally, an alternative approach to caring for people like B will show how cultural safety can be incorporated into practice.

Background

B is a 24-year-old pakeha woman whose recent admission to a surgical ward was for diagnostic purposes related to unspecified abdominal pain. B has an extensive medical file that documents a history of hospitalisations and investigative procedures. After presentation to the ward B exhibited a variety of emotional behaviours that ranged from angry, suspicious, and confrontational to euphoric and flirtatious. It quickly became clear to the author that B had mental health issues that were not being addressed within her status as a surgical patient. Concerns about cultural safety arose when the author witnessed numerous derogatory and unprofessional comments made about B by nurses on the ward. While the author can only speculate that B may have had borderline personality disorder (American Psychiatric Association, 1994) an almost complete absence of documentation regarding B’s psychiatric history and a lack of previously prescribed anti-psychotic medications added to the author’s concerns for her safety.

Cultural Risk

Cultural safety is defined as “The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family” (Nursing Council of New Zealand, 2002, p. 7). Cultural safety encourages nursing practice that does not demean, disempower or diminish the culture of the patient receiving care and these principles can be applied to all cultures. Cultural safety incorporates the principles of partnership, participation and protection under the Treaty of Waitangi, which aims to provide culturally safe healthcare for Maori (Wood & Schwass, 1993). It can sometimes be difficult to ascertain a patient’s cultural needs and in B’s situation

it is debatable whether she would have accepted the idea of a *cultural* association with other surgical patients who have a mental illness. However, as the subject of ridicule behind closed doors, B was associated with a negative interpretation of mental illness and indirectly demeaned and diminished as a patient on the ward. Her other cultural associations as hospital patient, woman, mother, partner/de facto wife, and daughter were largely ignored in preference for words like “manipulative”, “crazy”, “psycho” and “bitch”. Being labelled as a problem patient by staff meant B was not afforded equal care under the basic principles of the Treaty of Waitangi. The attitudes of many nurses on the ward meant that B was poorly protected from prejudice and unlikely to be invited to participate in her own care. By virtue of her behaviour B was deemed culturally different and, as Boychuk Duchscher (1999, p. 578) observes, “to be *labelled* dysfunctional or non-compliant is, generally, to be invalidated and disempowered”.

Nursing culture can have a tremendous influence on individuals who become labelled as “patients” upon hospitalisation and who are expected to acquiesce to nursing values and practices (Ramsden, 1993). The culture of the workplace can also influence and shape the attitudes of individual nurses to the extent they may be unwilling to negotiate and insist that patients adapt to ward routine (Morrison, Ramsey & Synder, 2001). Cultural risk existed because poor communication between B and the surgical ward staff failed to recognise each other’s respective worldviews (Nursing Council of New Zealand, 2002). Gatward (1999, p. 21) suggests that people labelled as manipulative “may not be good at empathising and are therefore less aware of how they look to others. This might explain why, despite wanting aid from others, their actions result in anger and hostility rather than care”. The cultural risk may have originated from a variety of sources: personally, from individual nurses feeling anxious about or ill-prepared to cope with B’s changeable behaviour (Brinn, 2000; Mavundla, 2000); institutionally, from a hospital that follows medical, legal, and historical practices that continue to treat mental illness and physical illness as mutually exclusive health problems; and socio-culturally, from stereotypes and the often negative depiction of the mentally ill in the mass media (Rogers & Kashima, 1998).

Ethical Considerations

New Zealand nurses are expected to conform to certain codes of practice. Among these are the requirements to act ethically (Nursing Council of New Zealand, 1995) and to incorporate several underlying values into practice including non maleficence and justice (New Zealand Nurses Organisation, 1995). The author believes that B’s nursing care was compromised by culturally unsafe practice because it failed to protect, advocate for, or assist in the expression of needs (non maleficence) and did not respect the needs, values, or dignity (justice) of this woman. Her interpersonal behaviour was different enough to warrant comment by the nursing staff. In spite of being aware that B had, as one nurse said “a personality disorder”, the failure to address this in her nursing care plan constituted unethical and potentially negligent behaviour. Several of the nurses on the ward showed antipathy toward B’s situation while others were often preoccupied with looking after patients they felt needed more attention. B’s complaints of pain or discomfort were occasionally dismissed by some of the staff as “attention-seeking”. Brinn (2000, p. 1) suggests that by avoiding the mentally unwell patients general nurses can “concentrate their efforts on others who will more than likely reassure them that they are competent...”. This comment is not an isolated one

in the literature; research has revealed that many general nurses feel ill prepared to care for mentally unwell patients (Mavundla, 2000). This may have been a contributing factor in B's nursing care.

Another related ethical issue arose - this time for the author. It was necessary to have the nursing staff, some of whom were uninterested in having students on the ward, sign assessment forms that were required for a passing grade in the course. However, the author believed the medical and nursing staff were not meeting B's psychiatric needs. The ethical dilemma for the author was whether or not to advocate for B's rights as a patient on the ward by addressing the issue openly with the nursing staff. This represented what Botes (2000) regards as a conflict between the ethics of justice, which is characterised by equality, fairness and impartial decision-making, and the ethics of care, which is characterised by caring and maintaining harmonious relationships from a holistic point of view.

In spite of the ethical requirements for safe nursing practice, there remains the danger of an unfavourable response for nurses (and students) who challenge the workplace culture. Armstrong (2002) reports that being labelled a "whistleblower" brings the likelihood of official reprisals, workplace ostracism, lawsuits, demotions, or job loss. The author discussed his concerns with one of the supervising nurses but chose not to risk potential workplace conflict that might have had a negative impact on both B and the other student nurses. Instead, the author decided to follow ethical guidelines (New Zealand Nurses Organisation, 1995) related to his care of B and to retain some amount of cultural safety by focusing on the bicultural nature of the nursing student-patient relationship (Ramsden, 1993).

Power Dynamics

Ramsden (2000, p. 4-5) states that cultural safety "is about protecting people from nurses, from our culture as health professionals, our attitudes, our power...[and the]... definition of safety should rest with the people who use our service". Within the dominant pakeha culture, nurses are seen as representing the norm while patients are viewed as the exotic parties in the relationship. Under this system it is nurses who have the power to define what is acceptable and normal (Ramsden, 1996). Thus, the importance of who holds the power, how they use it, and why they do so is moderated by perspective. A patient like B whose behaviour was unexpected and unwelcome probably constituted a challenge to both the culture of the surgical ward and to the power of the nurses. Conversely, B's "manipulative" behaviour was likely to be based on her conscious intention to gain a particular response from the nurses (Gatward, 1999) and this would indicate that her needs were not being met. Although the hospital policy statement about consumer rights states 'All providers involved in your care work together to ensure you are treated with the care and skill required to meet your needs' (Canterbury District Health Board, 2002), it is still acknowledging a one-way flow of power from the providers to the consumer. That the patient/consumer might be able to participate in this assumed partnership is far from clear.

B's experiences can be examined using critical social theory (CST), a form of social analysis that uses critical reflection to analyse the power relationships that are embedded in the structures and functions of society (Wilson-Thomas, 1995). Such an analysis provides a way to recognise institutional, cultural, and social ideologies that have been unwillingly or unknowingly internalised (Boychuk Duchscher, 2000). Emancipation,

the goal of CST, may be realized after the stages of enlightenment and empowerment have been achieved. Western biomedical healthcare is an ideology based on power, enshrined in law, and sanctioned through historical practice. It is 'proven' by the dominant cultural view that scientific method is the only method, and made exclusive and valuable by the high cost of education. Aside from being related to status, Kuokkanen and Leino-Kilpi (2000, p. 236) posit that power can be seen in terms of coercion and domination: "Power is extrapersonal, which means that an increase in power has to be compensated by someone else surrendering part of their power". By using language to label B as manipulative and by not considering any psychiatric care interventions, the nurses exercised cultural power that reduced the chance for B to attain enlightenment and empowerment in the management of her care. From a cultural safety perspective, the author believes B was part of a minority culture that is entitled to the protection afforded to all cultures under the Treaty of Waitangi (Wood & Schwass, 1993).

Revisiting Cultural Risk

It would have been possible to avoid the culturally unsafe and ethically questionable behaviour associated with B's care on the surgical ward. In considering this situation, the author believes that nurses themselves need to feel empowered to provide culturally safe nursing care within the broader medical culture of hospitals and in a political economy where healthcare is regularly restructured. Workplace settings should encourage environments that promote interpersonal and multi-disciplinary conversations that are free from threat and guilt (Spence, 2001). Both undergraduate and postgraduate students need to consider exposure to mental health issues that can assist general nurses to feel more prepared to manage medical-surgical patients who are mentally unwell (Brinn, 2000; Mavundla, 2000; Slevin & Sines, 1996). Empowerment through partnership and participation is a realistic and practical application of the principles of the Treaty of Waitangi.

B was "a regular attendee" at the Emergency Department usually for similar unspecified abdominal pain. This could indicate behaviour symptomatic of adopting a 'sick role', perhaps to avoid blame for the illness, be exempt from some social responsibilities, or justifiably seek out medical assistance (Abercrombie, Hill & Turner, 1988). Alternatively B's behaviour may reflect a growing trend identified by Weaver and Wilson (1994) where patients are increasingly taking less responsibility for their health care, have poor understanding of aspects of their care, and have little input into the management of their health problems. A partial solution proposed by Weaver and Wilson and endorsed elsewhere in the literature (Fraher & Limpinnian, 1999) is to encourage patient empowerment with the patient as the centre of the healthcare team. Nurses, as agents of the Crown are required to honour the principles of the Treaty of Waitangi (Nursing Council of New Zealand, 2002), and could consider such an approach, which respect the patient's lived experience. The principles of partnership, participation and protection underpin the Crown's obligation to make healthcare services equally available to all. The sharing of power, decision-making and resources, in combination with an understanding of historical, social, economic, and power relationships, could provide a culturally safe approach to meeting the health needs of people like B.

Conclusion

This paper has outlined the case of a young woman B who, in the author's opinion, received nursing care that was culturally unsafe. It was also acknowledged that B was not asked if she believed the care she received was culturally unsafe. Nonetheless, as a surgical patient with a poorly documented and untreated mental illness, B was exposed to cultural risk as effective communication and respect for different worldviews were not achieved between B and the nursing staff. Many of the nursing staff responded negatively to B's changeable behaviour by labelling her as manipulative and attention-seeking while also choosing to limit the amount of time they spent with her. Failure to instigate psychiatric care assessment appeared to compound the cultural stand-off between B and the nursing staff to a point where the principles of participation, partnership, and protection under the Treaty of Waitangi were not sufficiently addressed. Power relationships within the surgical ward were also considered using critical social theory, as were the effects of wider socio-cultural influences. Finally, B's experience was revisited from an alternative viewpoint advocating empowerment for both patients and nurses, with institutional support to assist in the provision of culturally safe nursing care.

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'Dynamic', 'Health Oriented' Rehabilitation? Rehabilitation and the Multi Disciplinary Team

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Introduction

“Rehabilitation is a dynamic, health oriented process that assists an individual who is ill or disabled to achieve their greatest possible level of physical, mental, spiritual, social and economic functioning” (Smeltzer & Bare, 2000, p. 119). In the acute medical setting, rehabilitation is an active, health directed activity involving the nurse and other members of the multi-disciplinary team, the client’s family and the client themselves.

To better understand the process of rehabilitation, it is necessary to outline the multi-disciplinary team’s role within the rehabilitation process in the acute medical setting. The various roles of the multi-disciplinary team members and the actions taken by them will be outlined with reference to some of the clients that I worked most closely with during my placement in the acute medical setting. The family/significant others’ roles in the rehabilitation process are then identified. A critique of the above quote and how it is not entirely achieved in the acute medical setting is included.

Rehabilitation in the Acute Medical Setting

In the acute medical setting of my recent clinical placement, the rehabilitation team developed a programme that was aimed towards the client achieving their “ideal health goals” (Canterbury District Health Board, 2001, p. 8). This programme was initiated on the admission of the client and continued to extend beyond their discharge.

Initially a “team of specialists”, the Multi-Disciplinary Team (hereafter referred to as the M.D.T.), assessed the abilities of the client to manage their health and “daily living tasks” (Christchurch District Health Board, 2001, p. 7). A programme was then tailored by the M.D.T, in consultation with the client, to achieve the client’s “optimum health goals” (Christchurch District Health Board, p. 8).

The M.D.T. in this medical setting included medical care, nursing staff, physiotherapist, occupational therapist, service co-ordinator, speech and language therapist, social worker and nutritionists. Each member is responsible for meeting their designated rehabilitation goals pertaining to the client they are working with. The following illustrates how the health goals were met by the members of the M.D.T. and their roles, as part of this “health oriented process” (Smeltzer & Bare, 2000, p. 119).

Rehabilitation Provided by the M.D.T.

Medical Care

“The aims of rehabilitation are maximal independence and quality of life acceptable to the patient” (Smeltzer & Bare, 2000, p. 119). The doctor’s involvement in the client’s rehabilitation results in the client’s diagnosis and medical treatment. This can be shown through their interactions with a client presenting with sleep apnoea. This

client had many sleepless nights prior to admission, resulting in fatigue and a potential safety compromise. With the diagnosis of sleep apnoea resulting in medicinal and respiratory treatment, this client was able to regain their energy and increase their safety. Therefore, the client was able to return home, a goal that had been set on admission in consultation with the physicians.

Nursing Staff

The nurses' role in rehabilitation is to give and coordinate the care of the client throughout their stay in the rehabilitation unit. The nursing process involving the "early identification of goals helps health-care providers focus on developing an individualised plan with realistic expectation...it helps patients focus on the next step to getting better" (Alfaro-LeFevre, 1994, p. 137). This was apparent in the nurses' application of the nursing process.

In consultation with a client who had sustained a fractured neck of humerus, a goal to have the client perform their self-care activities safely, with no assistance, was identified. Through the nurses' efforts to foster independence and gradually withdraw their assistance with the client's cares, this client was able to modify their actions physically to carry out their self-cares safely. As a result they were considered ready for discharge.

Physiotherapist

"Physical rehabilitation includes physical...therapy" (Kneisl & Ames, 1986, p. 358). In the acute medical setting, the role of the physiotherapist was to maximise the client's ability to mobilise, increase muscle strength and coordination.

A client admitted with a right cerebral vascular accident was helped to regain movement in the left, affected side. This included education on how to move safely while the affected side was strengthened. In this way, the physiotherapist was a key member in enabling the "physical functioning" of the client (Smeltzer & Bare, 2000, p. 119).

Occupational Therapist

The occupational therapist addresses some of the "social functioning" difficulties the client may have (Smeltzer & Bare, 2000, p. 119). The "occupational therapist aims to maximise the ease with which (you) the client perform(s) activities of daily living such as cooking, gardening, dressing and leisure activities" (Christchurch District Health Board, 2001, p. 8). An example of this in the acute medical setting was the use of cooking exercises. An appointment was made between the client and the occupational therapist. During this time, the occupational therapist assessed the client's ability to cook scrambled eggs on toast and make a cup of tea. The occupational therapist then usually recommended adjustment to the client that would enable this process to be easier for them. The client was then able to put these actions into practice if they wished.

Service Co-ordinator

"Rehabilitation is about restoring abilities and of returning to a full and satisfying life" (Donovan, 1990, p. 7). The service co-ordinator in the acute medical setting is there to ensure that adequate services will be available on the discharge of the client. This enables the client to continue 'satisfying' functioning at home. They are also there to refer the client to people who will address the client's "economic functioning" (Smeltzer & Bare, 2000, p. 119).

The package of services identified and coordinated by the service co-ordinator for a couple, where one person suffered from dementia was as follows; meal deliveries, carers, housekeepers, gardeners and respite care availability. Through these services being provided the couple was able to live at home with the help of the service providers.

Speech and Language Therapist

The role of the speech therapist was to “assist clients with disorders affecting normal oral communication” and swallowing (Potter & Perry, 1997, p. 72). In the acute medical setting this involved the speech therapist assessing the clients swallowing and communication difficulties and providing a plan of therapy. Information was given to the client, family, and nursing staff on how to effectively communicate with the client and/or how to prevent aspiration during feeding (the primary swallowing complication present in this setting).

Social Worker

“Psychosocial assessment of the acutely ill client should include a determination of the impact and meaning of the acute illness experience” (Johnson, 1997, p. 927). In the rehabilitation process, this applies to the incorporation of social support. The client is able to convey feelings to the social worker about the impact of their illness/disability.

An example of this was with a client who had been in the rehabilitation unit for three months. She failed to understand the extent to which her disability affected her. The client stated that she “felt fine” and could not understand that it would be unrealistic to expect her to be able to function as she was before her decline (personal conversation September 11, 2001).

The social worker sat with the client and was able to effectively bring the client to the realisation that she was not able to function as before. The client was able to recognise how the illness had contributed to her immobility and that perhaps returning home would not be a safe option. Therefore, the social worker was effective in bringing about the change in thinking necessary for the next step of this client’s rehabilitation – preparing for long-term care.

Nutritionist

“Nutritional therapy improves the nutritional status of patients who are debilitated by the...inability to maintain normal food and fluid intake” (American Cancer Society, 1986, p. 35). The nutritionist in the acute medical setting focuses on the clients who have lowered food/fluid intake. By conversing with the client and doing a physical assessment, the nutritionist was able to determine the required food/fluid intake in relation to the person’s health and treatment. The nutritionist then modified the client’s diet or other medicinal interventions were incorporated. Information was also provided to the client so they could make “informed choices about the food” they ate (Christchurch District Health Board, 2001, p. 9). This resulted in a halt in physical deterioration and an improvement in this client’s nutritional status.

Family Involvement in the Rehabilitation Process

Family/Significant Others

“The family provides ongoing support, participates in problem solving, and learns to provide necessary ongoing care” (Smeltzer & Bare, 1997, p. 120). The family and significant others play an important part in the rehabilitation of the client. At times, they can be the deciding factor in whether a client returns home or is moved to a long-term care facility.

An example of this is the admission of a client after a cerebral vascular accident and concurrent speech aphasia. This client mobilised in a wheelchair before his admission. He had the ability to stand while his wife transferred him from his wheelchair to a shower chair. On discharge of the client, the wife and husband had both been involved with the physiotherapist’s interventions to maximise mobility, but to weight bear again was not a realistic goal for the husband. Through intensive discussions by his wife at the family meetings, where she was adamant that she and her carer could continue to care for him at home, the husband returned home. If it had not been for the wife’s interventions, statements on behalf of her husband and her willingness to change their lifestyle at home, he would have been discharged to long-term care.

Critique of Quote

“Rehabilitation is a dynamic, health oriented process” (Smeltzer & Bare, 2000, p. 119). Higgleton and Seaton (1995, p. 290) define ‘dynamic’ as “relating to movement, forces.” Therefore it can be said that rehabilitation is an active health focused process. This is true in the acute medical setting. It is a process carried out by the M.D.T. who actively implement the goals identified by them and the client, to meet the client’s health needs.

Rehabilitation “assists an individual who is ill or disabled to achieve their greatest possible level of physical, mental, spiritual, social and economic functioning” (Smeltzer & Bare, 2000, p. 119). The physical, mental and social aspects of the client’s functioning are met in the acute medical setting. This was shown through the M.D.T’s identification of goals that related to these aspects of functioning.

The physiotherapist and medical staff addressed concerns regarding the physical functioning of the client; the social worker met the mental needs of the client; the speech therapist and the occupational therapist met the social aspects of the clients functioning and the service co-ordinator incorporated the economic needs of the client in the medical setting. The nursing staff helped address all concerns of the client through their deliverance and coordination of care. However, the spiritual functioning of the client was not addressed.

“Rehabilitation...has a strong commitment to the body as the object of intervention” (Seymour, 1998, p. 21). In the acute medical setting, the pre-printed patient care intervention plan followed the suggestion that people’s disability or illness should fit into the boxes next to each component of the body. Disabilities, or ways of care, were outlined next to each body part identified within the boxed region. There is no allowance for ways that the client may wish their ‘spiritual functioning’ to be cared for, or that the client may consider their ‘spiritual functioning’ as being disabled.

Spiritual “is used to describe thing that concern the spirit or soul, rather than the body or physical things” (Higgleton & Seaton, 1995, p. 931). The nature or importance of the person’s spirituality to them was not established on admission. The assumption was made that the clients who vocalised their beliefs identified their spirituality as being religiously based. For the clients with religious beliefs, available services included a chaplain and hospital chapel, with Holy Mass and Holy Communion celebrated on Sundays. The client was not asked if they wished their spirituality to be addressed in ways other than this, or if their spirituality was based within a particular religious denomination.

Conclusion

It was identified that during the rehabilitation process, a variety of members of the M.D.T. come together to provide active, health directed goals and interventions that help the individual achieve their “greatest possible level of physical, mental, spiritual, social and economic functioning’ (Smeltzer & Bare, 2000, p. 119). The involvement of the client’s family/significant others is also important in the rehabilitation process.

The rehabilitation process is centred on the client and their disabilities resulting in goals and interventions being formed. Therefore most aspects of client functioning are addressed by the M.D.T. during client rehabilitation, with the exception of the spiritual.

Spirituality is an intangible phenomenon and can not fit into boxes unlike parts of the body. According to Seymour (1998, p. 21) “rehabilitation, in the full sense of the term, may not be possible within the paradigm of scientific medicine.”

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An Attempt At Evaluation In Clinical Practice

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Introduction

The aim of this paper is to discuss issues involved in administering outcome evaluation questionnaires within the context of a clinical setting. A brief account of the outcome evaluation used in a mental health service will be given, but the main intent of this paper is to focus on the experience of undertaking evaluation in a clinical setting.

This paper will begin with a brief description of the objectives of Early Intervention for Psychosis and the role of case management in meeting the needs of the client. A rationale for evaluating client outcomes will be provided with a description of the process involved in the development of these evaluation measures. The paper will conclude with a discussion of some of the problems confronted in conducting outcome evaluation within a clinical setting. Recommendations for better facilitation of this process in clinical practice will be offered.

Description of Service

The service offers specialist outpatient treatment and support for young people between the ages of 18 – 30 who are experiencing a first presentation of psychosis. Members of the multi-disciplinary team, following a bio-psycho-social model, base treatment on intensive case management and individual treatment, for a period of up to two years. Treatment comprises group and individual programmes focusing on problematic drug and alcohol use, illness management, psycho-education, gender issues, recreation and creativity, relapse prevention, and anxiety/mood management. Family interventions include weekly support and psycho-education groups, and individual contact.

The service works as a specialist multi-disciplinary team, which includes case managers with backgrounds in Nursing, Social Work and Occupational therapy. Each adds a different perspective to the overall care of the client. This style of case management has been common in community mental health settings for a number of years.

A key element in early intervention is '*engagement with the client*' (EPPIC, 2001). When clients are admitted to Acute Inpatient Services, as is often the situation, the case manager endeavours to meet with the client within the first 2-3 days of admission. The case manager remains involved in all aspects of their care as an inpatient, and helps facilitate a smooth transition to outpatient care.

Aims of Service

A key to successful case management is establishing a therapeutic relationship with the client. This task can be challenging during the disruption and distress of a first episode of psychosis and acute treatment. For example, a case manager may have to balance a need to be assertive with medication against the need to establish a good rapport with the client and family. Engagement is a vital step in establishing a therapeutic relationship that respects and empowers the person with psychosis. Engagement can be a difficult process and can require considerable persistence and patience.

Clinicians are committed to following the EPPIC (2001) guidelines of case management in Early Intervention for Psychosis which are to: -

- provide ongoing monitoring of the client's mental state.
- ensure the client and family or carers are appropriately informed about the nature of the illness and its treatment.
- assist in minimising the duration of active psychosis. This may include facilitating the optimal use of medication.
- reduce the trauma or anxiety associated with any inpatient admissions.
- actively seek, and facilitate adequate treatment for, secondary morbidity and co morbid mental illness.
- assist in reducing any adverse impact of the illness on the client's psychosocial environment – for example, relationships, accommodation, education/employment, and financial security.
- foster the recovery of the client, reintegration into society, and restoration of a normal developmental trajectory.

Rationale for Evaluating Outcomes

There is a growing body of evidence that suggests that early intervention can reduce the recurrence rate and severity of psychotic disorders (Department of Health, 1999; McGorry, Edwards, Mihalopoulos, Harrigan & Jackson, 1996; Sheitman, Lee, Strauss, & Lieberman, 1997). This Early Intervention for Psychosis Service, began collating information in order to add to this evidence. As well as evaluating the effectiveness of the service, an essential aspect of this forthcoming data collection was assessing and monitoring the evolving needs of the client population.

The Early Intervention in Psychosis Guidance Note (Mental Health Commission, 1999) is a publication produced to provide mental health services with a guide to what they can best do for people presenting with a first episode of psychosis. Outlined in the Guidance Note is the need for teams to regularly audit/evaluate all aspects of their practice to ensure ongoing high standards of practice. It is important that the practices that contribute to effective treatment are identified and that services audit themselves to see how well they are doing. Early Intervention in Psychosis is an area where a considerable number of practices have not been fully evaluated.

In addition, the philosophy of Early Intervention is to invest extra resources in the early presentation of psychosis, in order to prevent the expensive and long term use of the limited mental health budget. This use of scarce resources must be justified by demonstrating improvement in long term outcomes. Therefore evaluation of Early Intervention Services was required. Ongoing evaluation should therefore be an integral part of any treatment team. Teams need to keep pace with evidence based literature and consumer feedback and where applicable, incorporating new information into practice (Mental Health Commission, 1999).

Since the service began five years ago, there have been significant changes in the demographics and symptom profile of the client population. In order to tailor the service to meet the changing needs of clients, it was hoped that extensive use would be made of the information collected through this evaluation programme. It was also hoped that this data would add to the growing body of literature, which strives for evidence-based medicine to drive best practice.

Research Planning in Early Intervention for Psychosis

The Research/Evaluation committee comprised a psychiatrist, two clinical psychologists and a researcher. This committee was responsible for determining which measures were to be used to collect the information, how this was going to be done and by whom. The measures aimed to evaluate how well the actual clinical practice was meeting the stated objectives. The committee needed to take into account the aims of Early Intervention in psychosis, (briefly described above) and the measures were formulated to evaluate these areas.

When the committee was initially planning to implement this outcome evaluation project, they discussed how best to collect this data. It was thought that the case managers would be the most appropriate clinicians to coordinate the data collection, as they were the ones who had the best engagement with the clients. Whilst the outcome evaluation involved interviews by the case manager, psychologist and the psychiatrist of each client, the responsibility for arranging these interviews lay with the case manager. Evaluation of the service should include not only symptomology but also feedback from the person and their family on the quality of care, including cultural safety, and quality of life, both inside and outside of the care facilities or services. This makes the process of evaluation extremely involved.

The present study was deemed by the Canterbury Ethics Committee to be an audit rather than a research project and therefore ethical approval and informed consent are not required. The implication of this was that all people who attend the service were evaluated, rather than just those who give their permission to be involved. This means a more accurate picture of client outcomes was obtained as findings are not just based on the clients who are fully engaged and compliant with treatment, and willing to engage in 'extra' paper work.

The reason for having evaluation measures was explained to all clients when they were accepted into the treatment programme. It was explained that the evaluations would assist in the ongoing development of a service which is responsive to the clients. Some clients did decline to be involved in the evaluations however, it was explicitly stated in the written (and verbal) service information that refusal to be involved in evaluations would in no way impact on subsequent treatment offered by the service. Case managers sign off that this information has been discussed with each client. Despite some refusals, a large quantity of information is gathered by the use of clinician-rated instruments.

The measures were administered at acceptance into the programme (baseline) and six monthly up to discharge at two years. These evaluations were to coincide with the six monthly review process, which had already been implemented for some time. The six monthly review is a multi-disciplinary team review to assess progress, outstanding issues, ongoing treatment, and discharge planning.

Problems with doing the evaluations

Implementing audit/evaluation in clinical settings can be challenging. To illustrate just how challenging, the following is a reply the research committee received from the Professor of Psychiatry at Yale University School of Medicine, to a question regarding outcome evaluation in First Episode Psychosis.

'You need to go back to whomever gave you this charge with the news that decent research cannot be done without extended assessment forms and training and that you cannot ever expect clinicians to do research'

These comments have proved to be somewhat accurate in this experience of implementing routine evaluations in clinical practice.

As time went by it was becoming obvious that there were difficulties with the clinical researcher/evaluator receiving the information within the specified time frame. There was much talk about the pressure the clinicians felt to collect the information, which sometimes impacted on the building of rapport and establishing a therapeutic alliance. The burden of the extra paperwork was also an issue. Clinicians were finding it difficult to justify both to themselves and the client, the importance and relevance of this information. In order for some of the measures to be completed the client needed to be transported to the service. This often meant a special appointment, as it was not always convenient to accomplish information collection within another appointment.

Fixing the Problems

Although at the initial planning phase of this evaluation it seemed most appropriate that the case manager be the co-ordinator of the data collection, the reality was quite different. Clinicians were talking about their discomfort in using their therapeutic relationship to accomplish the collection of data when the client was not getting adequate feedback from the measures being used. Seemingly the evaluation was being successful by way of the goodwill between the client and the clinician. The clinical researcher/evaluator then began to feed back some of the results to the case managers, but still it seemed that this was not enough. There was talk about the hope that the data would be used to assess and monitor the evolving needs of the client population. From this it was hoped that the service would be shaped to meet the needs of the clients.

The most crucial aspect of implementing an outcomes management system is determining how to use the information that has been gathered. Most important is that feedback be given to the clinicians to facilitate improved treatment. The ultimate aim was to improve clinical performance and client outcomes. Organisations will differ in the ways in which they use the data. The outcome data will be more effective in the long term when it is used to stimulate discussion, to guide clinicians in tailoring client treatments, and to identify efficient approaches to treatment (Smith, Fischer, Nordquist, Mosley, & Ledbetter, 1997).

There have been quite differing responses from the clients. Some appreciated the feedback, which compared their scores with others, and this has helped to normalise their experience by knowing what others have scored on these measures. Some also found it useful in gauging their progress over their time with the service, and appreciated the discussion that went with completing the measures. Answering the questions was a good time for reflection on their experience of first episode psychosis, and what it has meant for them and their family/whanau. For others it seemed that they complied with the request due only to their relationship with their case manager, and they found that the measures had no tangible relevance for them.

As Case managers it would be advantageous to be able to offer some positive outcome of the data collection, which would be more meaningful for both client and clinician. This would also enhance the way in which explanations about the purpose of these measures were given when asking a client to participate in such a study. An example of how the data brought about a change in service delivery, or how a part of the

programme was developed in response to a need which was identified by the outcome of these measures, would have more meaning for both client and clinician.

Consultation and discussion with mental health staff is necessary to address the issues of ownership of an evaluation/audit project. Clinicians should be given the opportunity to share responsibility for the health outcomes approach. It is crucial to take the time to ensure the ongoing commitment of the clinical staff to the project, and include representatives from the multi-disciplinary team in the planning and implementation of any projects. It is also desirable to make every effort to avoid unnecessary complexity, inconvenience and tedium for clinical staff, bearing in mind that a high volume of paperwork can be conducive to burnout (Crocker & Rissel, 1998).

Recommendations

With hindsight, there are some key issues, which must be addressed when embarking on a service evaluation with clinical staff collecting the data.

- The initial research planning committee did not have case management representation. The research/evaluation committee now has three case managers involved, and it is recommended that this be a requirement for any team looking at evaluation outcome or conducting research in clinical practice.
- Clinicians responsible for data collection to be involved in the development of any project.
- As the collection of this information is additional work for clinicians, additional resources must be made available to enable evaluations to be conducted, recorded and utilised.
- Clinicians need to have regular feedback on the progress of the client in order for the clinician to see some tangible results from the evaluation. This information can confirm clinical impressions.
- This regular feedback can also be given to the client and used as a guide for marking progress and a tool to assist in treatment planning.
- In order to tailor services to meet the changing needs of the clients, extensive use should be made of the information collected through the evaluation programme.
- As well as evaluating the effectiveness of the service, an essential aspect of the data collection is to assess and monitor the evolving needs of the client population.
- What can and cannot be achieved by these sorts of evaluations, and the reason for doing them, needs to be clearly articulated to funders, clinicians and clients.

Conclusion

The implementation of outcome evaluation has been of mixed success. Lessons have been learnt as outlined above. Although information has been gathered on 113 clients, it has been an ongoing struggle within the team to collect the information as per the original plan. The issues raised by clinicians are indicative of the burden felt with this extra workload. The time spent completing paper work, transporting clients to appointments and the ongoing conflict of justifying this with the client were negative aspects of the evaluation. There was also much talk about feelings of resentment at not being included in the preliminary planning.

The Mental Health Commission (1999) guidelines, identified research as an integral part of any Early Intervention team, in order to audit and evaluate the service that is being provided. The need to adequately resource the collection of information in a

study needs to be addressed and actioned in the initial stages of the research proposal. Both managers and researchers need to learn the lessons outlined above, in order for evaluations to be meaningful and more readily acceptable.

The drive for evidence based practice within mental health nursing needs to have the co-operation and commitment of clinicians if it is going to be reliable and valid. It also needs to properly inform treatment and meaningfully influence resource allocation (Walter, Cleary & Rey, 1998). While evidence based practice is the way forward for mental health nursing, evaluations cannot be meaningful without the backing of clinical staff.

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An ethical position on the administration of pain relief to a dying patient

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Introduction

Beneficence (to do good), nonmaleficence (to do no harm or to minimise harm), autonomy (freedom of self-determination) and justice (fairness to all) are four ethical principles that health professionals can utilise to guide ethical decision-making (Beauchamp & Childress, 1994). This approach to ethics is commonly called 'principle-based' ethics. This article will develop an ethical position on the administration of pain relief to a dying patient using this approach.

To assist in the development of a position, an ethical dilemma will consider whether it is more important to give adequate narcotic pain relief and risk hastening death, or whether the patient dies unassisted, in pain and suffering air hunger. A narrative, in the form of an exemplar, will highlight the qualitative aspects of a nurse's experience of giving care to a dying patient. Both positive aspects (relief of moral stress), and negative aspects (disparity of power) of negotiating care that is morally right for the patient will be considered.

This article will argue that, despite the limitations of power disparity, negotiation is recommended as the tool of choice to make ethical decisions relating to pain relief and palliative care. It is accepted that it is the doctor's right to make these decisions however, the doctor has an ethical obligation to involve the nurse, the patient and his/her family in the decision making process. Many nurses need and want to be involved in this process. All parties concerned have a right to determine beneficence, nonmaleficence, autonomy and justice regarding the patient, especially if the patient's autonomy is compromised.

Concepts defined

A *moral dilemma* presents a choice of two unwanted alternatives (Sletteboe, 1997). The unwanted alternatives depicted in the exemplar are, respiratory depression and pain. Johnstone (1994) points out that when a person is unable to translate their moral choices into moral action, *moral distress* results. *Disparity of power* can be a contributing factor to moral distress and, according to Slomka (1992), when members of a negotiating team claim power unequally, *disparity of power* occurs.

According to Erikson, Rodney and Starzomski (1995), *euthanasia* comes from a Greek word meaning 'good or pleasant death'. It is generally classified as being either passive (allowing to die) or active (helping to die). *Cessation of treatment* means allowing someone to die by discontinuing active intervention toward cure when cure is no longer possible. This can incorporate both withholding treatment and withdrawing from treatment. Cessation of treatment does not mean cessation of comfort and palliative care, nor does it mean active euthanasia or assisted suicide.

Palliative care is a form of treatment offered to patients who have a 'definitely diagnosed terminal illness' for which there is no further useful curative therapy or where the patient refuses such therapy. Palliative care is instituted with the informed consent of the patient or substitute decision maker (usually next of kin). Treatment is intended solely to relieve the person's suffering and is not the deliberate infliction of death (Grant, 1993).

Exemplar from practice

The following exemplar describes an ethical dilemma from which an ethical position will be developed.

Mrs A is a 73-year-old woman admitted with an acute exacerbation of psoriasis. Her integumentary system has been further compromised by an adverse reaction to a medication that was intended to help heal her skin, and a stroke that she sustained in hospital. Areas of her skin lift off each time she moves and she is in pain, which is an awful shock for the family. I negotiated with the medical staff to start a morphine infusion to bring some relief to this suffering woman. The infusion began and she was subsequently sent off the ward to have a central venous catheter (CVC) line inserted for antibiotic treatment.

Whilst away, the escort nurse noticed that Mrs A's respirations had slowed considerably and queried respiratory depression. Meanwhile I had been phoned to help bring Mrs A back to the ward. The doctor who had inserted the CVC line had turned the morphine infusion off meanwhile. He told the escort nurse and I, that Mrs A was ready to go back to the ward. "Could you give her some Narcan" (reverses the effects of a narcotic), I requested? Imagine a person ceasing to breathe whilst you're still in the elevator on your way back to the ward. It hardly bears thinking about. Narcan was administered and we went back to our ward.

Now, what about the morphine? On review by the medical team the infusion was crossed off the medications chart, and 1mg morphine was charted intravenously, as required. Respirations were to be greater than 12 per minute. The duty ended and I went home. The next day Mrs A had deteriorated further. Her whole body heaved as she seemingly gasped for breath. I was filled with dread. The doctor arrived and began stabbing a long needle into her femoral artery. She slid down the bed trying to escape it. Her colour became cyanosed and her breath etched its way out. "Please can I suction Mrs A?" I asked. He kept manipulating the needle. "She needs suctioning," I said as I anxiously hooked up the suction equipment. She was purple. Can't he see her airway is compromised? I turned the suction on and manoeuvred my way between them to help ease Mrs A's breathing. I withdrew a mucous plug and her colour improved. Time to stand back and let my heart rate return to a more normal rhythm. The doctor made his exit and I was left with Mrs A and her agony. Morphine 1mg was a start, but I knew as I gave it to her that it would be insufficient. I went back to negotiating with the team. "We need more pain relief for this woman," I urged. "Those respirations need to stay above twelve per minute," I was told. "But she's in pain and she's dying," I said. "We'll keep up the antibiotics and maybe she'll turn for the better." I felt overcome. Back with Mrs A, I cleansed her body, repositioned her to facilitate better lung expansion and hugged and comforted her 'pale faced' family. The odour of exudating skin filled the room. Compassion filled my heart for this lady.

The morning progressed, Mrs A continued to gasp for air and Mrs A's family and I tried to comfort her. I spoke to one of my nursing colleagues about how my day was going and that the doctors wouldn't adjust the morphine dose because of decreased respirations. She suggested that I ring the consultant who headed the medical team. What a good idea! Take it further, I like that! I gathered my wits and prepared to ring the consultant. As I walked down the corridor to the phone I saw the consultant sitting behind the desk. What welcome relief! I approached and briefly explained the last two days. "The thing is," I said, "she's dying." He stood up immediately and said: "Well!" "Let's go and do something about it!"

As we entered her room I instinctively touched the consultant's arm. Mrs A had stopped breathing. The gasping had stopped and her family was weeping with grief and, I assumed, relief. Both the consultant and I comforted the family and then left them with Mrs A. As we walked down the corridor the consultant said to me: "Any time you are faced with this again you can call me, day or night." A week or so later the consultant approached me and began talking about Mrs A and her last days. "That must have been quite awful for you," he said. "Oh, you know, we get by, we just try to keep the patient comfortable," I garbled out, unthinkingly. "It must have been awful for you though," he repeated. "It's alright for us doctors to view the patient, write down some instructions and then walk off, but you nurses have to stay with the patient all the time and see what they're going through." "You're right," I said, "it isn't easy." "Remember, you can ring me anytime," he reiterated. I smiled and we both carried on with our respective duties.

Constraints on nurses' ethical decision-making

This scenario poignantly describes the type of dilemmas nurses face. Johnstone (1994) highlights that if nurses cannot distinguish between ethical dilemmas and hospital etiquette/policy or following a doctor's order, they can run the risk of failing to prevent ethical errors and harms from occurring in health care domains and may actually cause them to occur. It is also important to emphasize that hospital policy, public opinion or following the orders of a superior can place the nurse in a dilemma where she is faced with choosing between unwanted alternatives (Sletteboe, 1997).

According to Edwards and Habbad (1988, cited in Beckel, 1995), a physician's request is the most common reason for nurses to compromise their ethical values. Davis (1982, cited in Beckel, 1995) suggests that the strain between nurses' professional role, their obligations to a patient and their employee status, as well as their obligation to the institution and the physician becomes a major issue in the nurse's struggle to be the patient advocate. Yarling and McElmurry (1986) also express concern that nurses are often not free to be moral in that they are constrained by hospital policy as well as the role and social position of the physician.

Where this story becomes an ethical dilemma for the nurse is that she was unable to give a dying patient enough pain relief because the medical staff feared Mrs A might die from a morphine infusion. This supports Ericksen et al's (1995) contention that most disagreements between doctors and nurses are about the patient's need for analgesia. From the nurse's perspective, adequate pain relief was promoting beneficence; inadequate pain relief was inflicting harm. It seems that the medical staff's perspective of beneficence and arguably, nonmaleficence was that Mrs A's life was to be preserved. Clearly in this scenario, there are competing interpretations of beneficence and nonmaleficence. Sletteboe (1997) suggests that values may either compete or be in

conflict and in this instance it appears that the nurse and the medical team valued different outcomes. The nurse cared for Mrs A's body as best she could but was agonising over Mrs A's state of air hunger and pain level, not to mention the distress of the family. The medical staff prescribed (antibiotics), and did not prescribe (adequate morphine), medication to prolong life in the hope that some semblance of recovery might be attained.

Goff Jett (1995) believes that both doctors and nurses face feelings of reluctance to medicate effectively in the final phases of life for fear of hastening death through respiratory depression. Goff Jett also points out that what can be overlooked is that respiratory depression occurs naturally as the moment of death nears anyway, and clinicians can get all caught up with worrying that it is their fault. I certainly felt quite anxious about counting the respirations of Mrs A and making sure they were above twelve before I gave her morphine, and yet I knew she was dying, respirations were being depressed naturally anyway... what a dilemma!!!

Johnstone (1994) addresses this dilemma. She explains the alleviating pain/hastening death battle as *analgesia with unintended death*. There are pain states that can only be relieved by narcotics and that the administration of these is often at a level which may compromise a patient's alertness and physical ability, and may even render them semi-comatose (as had happened to Mrs A whilst having the CVC inserted). Death can be hastened, even if not directly intended. Johnstone highlights that this is not the norm, although it occurs frequently enough to be of concern to nurses. Gormally (1994), in addressing passive euthanasia, suggests that there should be no seeking to bring about a patient's death either by action or omission. Seeking to bring about death is, however to be carefully distinguished from **not** seeking to prolong life.

The nurse as advocate

Quite often family members will share with the nurse their own fears, values and wishes, as well as the knowledge they have about the patient, because the nurse is there and is trusted and supportive (Erickson et al. 1995). The nurse often acts as mediator on behalf of the family. Hollows (1995) expresses the view that the nurse-patient relationship insists on personal involvement, moral struggle and emotional investment. This is not only with the patient but also with the people significant to them. Therefore, nurses often have valuable insights as a patient advocate.

The family as advocate

According to Beckel (1995), family members, or guardians of the patient can represent the values and goals of the patient who is unable to do so for him/herself. Family members also hold desires and needs surrounding the possible death of a loved one. Paternalism of the physician or other health care professionals can be ruled out when autonomy and respect is given to the patient by facilitating negotiation with the family/guardians. Wanzer (1989, cited in Beckel) suggests that doctors may not sufficiently understand or value the patient's role in medical decision-making or may be unwilling to relinquish control of the decision-making process. Erickson et al. (1995) suggest that some physicians believe that the decision to stop treatment is theirs alone and that life must be preserved at all costs.

Erickson et al. (1995) suggest that the processes by which health care teams (professionals, patients and family members) make decisions about cessation treatment are fragmented.

This often arises because of the inadequate involvement of patients and families as well as the inadequate involvement of nurses, who often feel shut out of treatment decision-making. As a consequence, nurses often experience *moral distress* when they care for dying patients, in that they are unable to translate moral choices into moral action. This is associated with feelings of guilt, anger, frustration and powerlessness (Johnstone, 1994). Hollow's (1995) research study found that five registered nurses wanted to be more closely involved in decision-making processes and that this involvement can help reduce nurses' stress.

Negotiation

Earlier, the perspectives of the nurse and the medical staff were outlined. The perspective of the patient could only be ascertained by assuming what might be 'good' for the patient as her autonomy was severely compromised. However, according to Slomka (1992), there is another valuable member of a negotiating team and that is the family or guardians. Slomka suggests that the moral responsibility for the patient's death by withdrawing treatment should be shared with family members/guardians. Arguably this would promote a fairer outcome for all and thus promote the principle of justice.

Part of the process of negotiation within the healthcare team is the overall sharing of the moral responsibility of the resultant decision. Slomka (1992) terms it 'negotiation of death'. In this negotiation each party, with their different view of the 'truth' in a situation, attempts to make their view prevail. The question often being "is the patient's condition hopeless or is there a chance for recovery?" Slomka continues that the success of each person involved in the negotiation will depend on the position of relative power each person can claim in the context. Often it is the physician who holds the most power. Scheff (1968, cited in Slomka, 1992) suggests that this is because society confers on medicine symbolic power and authority because of doctors' apparent skill in controlling the meaning of the patient's prognosis. Doctors can present the facts subjectively, thus affecting the family's interpretation of the patient's situation. It seems that language used by the doctor can easily flummox other members of the negotiating group. Thus it seems, that due to power disparity, justice, where fairness to all is valued, may be the most difficult principle to promote within this particular scenario.

Negotiation *has* its limitations, however it does pave the way for an ethical decision-making process, one in which beneficence, nonmaleficence, autonomy and justice can have expression. Slomka (1992) illustrates negotiation between medical staff and a family in a case study where the result was turning off a respirator. Doctors provided the patient with analgesia and sedation to prevent suffering from air hunger. This was denied Mrs A. Goff Jett (1995) points out that often, dying patients are subjected to unnecessary procedures and are denied control of devastating symptoms of pain and air hunger. This is where technology does not prolong an acceptable quality of life but simply prolongs the process of dying, adding pointless pain and distress rather than enhancing a peaceful death.

Collaboration

Ericksen et al. (1995) stress that interdisciplinary team communication and collaboration must be strengthened and that all voices must be heard, including the voices of the patient and family. This facilitates an optimal decision-making process. Edwards

(1993) believes that ethical dilemmas can often be traced to simply a lack of communication. The doctors are not talking to the nurses, the nurses are not talking to each other, and no one is talking to the family or the patient. Edwards also suggests that it is important that nurses gather the facts. A doctor may not value a nurse's opinion of a case but may be persuaded by well-presented information that supports the nurse's argument. This also highlights the imbalance of power and how hard nurses have to work to be listened to.

Brown, Kitson and McKnight (1992) suggest that what is commonly accepted is the desirability of patients and family members to avoid a process of dying which is extended, painful and traumatic. Beckel (1995), describing the hospice movement, suggests that a peaceful death is a desire shared by patients, family members, nurses and doctors. Furthermore, Wanzer (1989, cited in Beckel, 1995) promote that a good death is not simply withholding of technological treatments that prolong the act of dying, but it is also deliberately creating a medical environment that allows a peaceful death. Thus, negotiation can bring different perspectives on death, all of which warrant consideration. Thoughtful consideration of each perspective has the potential to contribute to a 'good' outcome for the patient.

Conclusion

So... utilising negotiation between all within the health care team can promote a more balanced interpretation of what might constitute beneficence, nonmaleficence, autonomy and justice for the patient and their family. Through proper consultation with the patient, family members and the multidisciplinary team, a patient's right for self-determination can be respected. Doctors need to acknowledge when a person is dying, stop treatment with the view to getting better and prescribe adequate pain relief. If the patient dies sooner because they have been given narcotic pain relief (and who can be sure?) then good has been done for that person, not harm. If the intent is to facilitate a peaceful death, then technology has helped and not hindered that process.

Proper consultation relieves the anxiety of the nurse and the family who watch and comfort the dying person. It diminishes the grief felt by family members knowing that they have been heard and have been a part of the decision-making in the life/death of their loved one. Proper consultation also helps to deal with the enormous burden nurses face when left with medical instructions that places them in an ethical situation where they experience moral distress. As Grant (1993, p. 34) says, "*it is vital that nurses, as front-line health care professionals, be involved in the debate over life and death decisions.*"

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Gender and health promotion: A feminist perspective

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Throughout the twentieth century feminist thinking underwent radical change as the women's movement gained momentum. The social movement of feminism has embraced many guises, from liberal, to Marxist, to the postmodern. However, critical understanding of the experience of women's oppression has remained the *raison d'être* of feminist thinking. The relevance of feminist scholarship within the interrelationship of gender and health care will be analysed and debated in this article, through the dominant discourse of health promotion.

Gender has a profound impact on all aspects of people's lives. The different reality of the lives of men and women is inherent in their every day existence; their relationships, work, ambitions and their pleasures (Wearing, 1996). Gender can be seen as a range of social behaviours and personal attributes incorporated into two concepts, femininity and masculinity (Cheek & Rudge, 1996). Throughout the decades, these two categories of gender have created much debate and an ongoing unresolved division within all aspects of society.

Health promotion, as one aspect of the health system cannot escape gender scrutiny. Just as feminist thinking cannot be divorced from politics and ideology, neither can health promotion (Caraher, 1994). Health promotion is a nebulous and ambiguous concept, which works to integrate notions of wellness, positive health and disease prevention. Lack of a succinct and concise definition however, does not prevent recognition of the key components, namely health enhancing activities, health education, protection and disease prevention, all of which encompass and contribute to the concept of health promotion (Delany, 1994).

The World Health Organisation has been at the forefront of the international health promotion movement throughout the twentieth century. The ideology which drives this movement stems from the identification of '...the existence of gross inequalities between advantaged and disadvantaged peoples which is politically, socially and economically unacceptable' (Tones & Tilford, 1994, p.3). The desire by the World Health Organisation for health promotion to be a unifying concept, requiring a change in the ways and conditions of living, appears to combine personal choice and social responsibility. The dual emphasis inherent in this statement, Delany (1994) contends, is lifestyle and living conditions, both of which impact, albeit very differently, on women and men's health.

Williams (1989) argues that the epistemological basis of health promotion derives from classical liberalism, the political ideology of many Western countries. The three key assumptions of liberal theory, individualism, rationalism and human motivation constitute the ideology based on patriarchal hegemony. Acknowledging liberalism as the antecedent theoretical base of health promotion therefore, could make this health concept problematic for feminist thinkers. The assumptions inherent in liberal theory regarding human nature, are derived from the experiences of white privileged men, thus they have little, if any relevance for women (Jaggar, cited in Williams, 1989).

Moreover, it is this liberal perspective that is the basis for the majority of health promotion programmes and could be considered the dominant discourse within health

promotion. This dominant voice, which has arisen from the complex integration of social, historical and political factors, is apparent within the medical hegemonic lifestyle approach (Cheek & Rudge, 1996). Within this discourse, the major determinants of health are identified as life style and personal behaviour, which in turn assumes individual responsibility for personal health outcomes (Williams 1989). Viewing the health problem as essentially intrinsic not only victimizes the person, but rejects a range of alternative realities. The social, political and economic determinants of health are ignored as are the social categories of gender, race and class

Liberal feminism, the feminism derived from liberal theory found that full equality of opportunity for all people with out regard for gender or the social context, was unrealistic and unachievable. Accepting all people have freedom of choice and equal opportunity to achieve, ignores the lived experience of the many people constrained by social structures within society. Clarke (1992) agrees and contends that contemporary health promotion research, steeped within the positivist paradigm, assumes that women and men use the same language, have similar employment and educational levels, and inhabit equivalent social worlds. It is inadequate to group together all women or men when analyzing health care with scant or no regard for the notion of gender. Such research fails to acknowledge that the experiences of women, ethnic minorities, the poor and marginalized, differ greatly from men, and are often invisible (Williams,1989). It is important to acknowledge however that even within these marginalized cohorts there is little or no homogeneity.

For many years, debate has raged as to the determinants of health for both men and women. Biomedical, social and cultural explanations have been posited without definitive answers. Over the last two decades increasing evidence has shown that the variations within the health of women and men cannot be adequately accounted for within biomedical explanations (Sabo & Gordon, 1995). These writers contend that as biomedical explanations fail to provide adequate answers, there is a growing acceptance of socio-cultural explanations. These however, are insufficient without the social category of gender.

Gender as a social construct influences both the health of people and the treatment each person receives (Grbich,1996). How strongly that influence is felt is demonstrated within the burgeoning area of men's health. The paradox of health promotion is apparent in this health arena as it is acknowledged men have greater access to social, economic and health resources, yet their health status continues to deteriorate. New Zealand men have an average life expectancy of 73.7 years in comparison to 79.1 years for women (Ministry of Women's Affairs, 1998). Longevity has increased for both cohorts since the 1950's, however, the gender gap has widened for the life expectancy of women from four to nearly six years (Raeburn & Sidway, 1995). Feminist thinkers have argued that the feminist construct of gender is detrimental to women's health. Is it possible that the social construct of masculinity could have a negative impact on the health of men as well as women?

Connell (1987) argues that central to the interrelation of femininity and masculinity is the global dominance of men over women. However, within this relationship are certain masculinities and femininities that constrain alternative expression and could be seen as detrimental to health. Hegemonic masculinity emphasizes aggressiveness, competition, size, physical strength and phallocentricism, while emphasized femininity focuses on dependence, passivity, nurturance, cooperation and sexual submissiveness (Connell). Heterosexuality as the centre of hegemonic masculinity, negates other forms

of masculinities. Moreover, Connell suggests that other forms of femininity do not suffer the same fate and this may provide the diversity of femininities within society. It could be argued that it is these extremes of gender construction that impact negatively on health. Gender construction without fixed category would enable the diversity apparent in women and men to be expressed. Bohan (1997) suggests that this could make available all modes of being for both women and men within a supportive context.

Whilst it is argued that the dominant discourse of health promotion has failed to distinguish between the health needs of women and men, Cheek and Rudge (1996) contend that health practices are suffused with understanding about gender. The influence of gender is made apparent in the focus taken for health policy and programmes. Women's health is frequently linked to their reproductive capabilities, with cervical and breast cancer screening programmes predominating. Men's health is more likely to be threatened by smoking, excessive use of alcohol, poor nutrition and drinking alcohol and driving. Coronary heart disease is often perceived as an issue for men and is the focus of many health promotion programmes, targeting exercise, diet and smoking. Without regard for gender, lifestyle changes are exhorted, with limited success, while socio-economic determinants are ignored. Williams (1989) discusses recent research which demonstrates heart healthy behaviours directly linked to education, economic and employment status. She argues that given the overrepresentation of women and ethnic minorities among the unemployed and poor, the effectiveness of individualistic health promotion campaigns must be questioned.

Although medical hegemony remains dominant within health promotion discourse, other voices are beginning to emerge (Tones & Tilford, 1994; Williams, 1989). Willingness to examine alternative perspectives that incorporate the social issues of age, ethnicity and class are essential for positive health outcomes. These social issues Cheek and Rudge (1996) argue, further compound the effects of gender. The World Health Organisation continually raises the spectre of health beyond the lifestyle of the person, and argues that health inequalities between and within nations and social groups requires eradication for health to be achieved (Tones & Tilford, 1994). Becker (1986) however suggests that the recognition of issues such as poverty, sexism, racism, unemployment, and environmental and inequity issues could be both complex and threatening.

In recent years the concept of health promotion has become a desirable arena for many health professionals and interest groups. Nurses have been one group who have considered themselves to be ideally suited to this branch of health care, with varying degrees of success (Delany, 1994; Kermode, 1995). It could be suggested that as nurses are predominantly female, feminist ideology would predominate in health care activities. Kermode argues otherwise and believes that many nurses continue to practice within the reductionist paradigm and as such concentrate on assisting people to cope rather than to change their circumstances. He further argues that by accepting the individualistic health promotion discourse nurses contribute to the suppression of the radical critique of the social determinants of health. The need for social and political activism incorporating gender, class and race in health promotion has proved problematic for many nurses working in a context of medical hegemony. Perhaps Connell's (1987, p.186) contention that "what most women support is not necessarily what they are" will provide solace for those nurses eager to understand the complexity of gender issues within the health care arena.

Within the positivist, reductionist paradigm, health promotion appears to be problematic for women's health. As health promotion burgeons into a valuable asset for business as well as society, the intersection of capitalism and patriarchy becomes evident once again. Although feminist thinking remains unconvinced of post structuralist possibilities, it is suggested that a poststructuralist feminist paradigm may be fluid, inconsistent and contradictory enough to challenge the fixed notions of gender and the hegemonic structures of health promotion. Poststructural analyses would not accept as given the social categories of gender and gender relations, and would also challenge the unitary notion of women's or men's health (Cheek & Rudge, 1996). According to Williams (1989) a feminist view would challenge the dominant discourse of health promotion not only for its inadequacy, but also for its perversity in accepting that human behaviour can be abstracted from the social context. Feminist thinking recognises that each woman and man has different and therefore unique social and health experiences. It is impossible to discuss femininity and masculinity as homogenous categories. Acknowledgement of this understanding would only enhance the health of all women and men.

In summary then, using gender as the central thread, a feminist lens has been used to consider and analyse the dominant discourse of health promotion. Identified as being firmly ensconced within the biomedical arena, with epistemological antecedents in liberal theory, this discourse was recognized as being detrimental to the health of many women. The gendered construction of health promotion can strongly influence health outcomes for both women and men. However, the homogeneity in which these two groups were perceived was challenged for ignoring the multiplicity and diversity of health experiences that occur within the social context. Finally, it was suggested that feminist scholarship could offer an understanding of the roles the category of gender and gender relations play, in defining health experiences for all people.

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Discourses on madness: An analysis of media representations of the Canterbury Mental Health Nurses strike.

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Paper presented at Australian and New Zealand Mental Health Nurses 28th International Conference. 'Coming of Age: A celebration of Mental Health Nursing'. 15-18 October, 2002, Sydney.

Background: In late 2001 Canterbury mental health nurses undertook a variety of strike actions after the stalled industrial negotiations with the district health board. One response to these actions was the reduction, and in some instances the complete closure, of many of the regions mental health services. Unsurprisingly, the print media responded by publicising the crisis in mental health services on a daily basis. Apparent among such reports, however, were themes of politicised agendas. Consequently, research into print media representations of the industrial disputes was undertaken utilizing discourse analysis.

Results: Emergent results of the research reveal themes of juxtaposed images of both mental health nursing and of consumers of services. These themes are analysed within an historical and current socio-political context, and compared with other analyses of media representations. Finally, implications for mental health nursing and for consumers will be discussed.

Conclusion: Media representations of the recent industrial action reveal politicised discourses that can negatively affect nursing and consumers. Such representations need exposure to allow redress.

From Hospital to Home: The Successful Discharge of a Ventilator Dependant Tetraplegic Patient.

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Paper presented at the College of Nurses Aotearoa (NZ) Annual Conference "We are able and artful nurses" 19-20 September, 2002, Nelson.

In 2001 I completed an advanced nursing practice paper offered by Otago Polytechnic, in conjunction with Christchurch Polytechnic Institute of Technology. I wish to share the experiences I encountered which demonstrate the need for nurses to be able and artful. To provide some background information I will outline the influencing factors that provided the opportunity for me to undertake such a unique challenge of co-ordinating and implementing the discharge of a ventilator dependent tetraplegic patient from the Burwood Spinal Unit to his home environment via the Waiatapu High Dependency unit. We had not experienced discharging a ventilator dependent tetraplegic patient directly home before and therefore limited documented information or resources to guide this process were available.

The amount and variety of personnel, organisations, resources, equipment and consumables spread across both hospital and community settings that I liaised with were extensive. Because of the limited time involved to prepare for discharge, expert advanced skills were required to ensure that a smooth discharge process was accomplished. To promote the concept that we are able and artful nurses, using critical reflection, supported by advanced nursing practice and home mechanical ventilation literature, I will discuss several incidents that I encountered which required resourcefulness, intuitiveness and skilful practice.

An update of events since discharge will enable further discussion and aid in the evaluation of the success of the discharge process. This evaluation process provides the opportunity to formulate recommendations for future practice to ensure that there are evidenced based documented resources available for the future, thus improving community reintegration and patient outcomes.

Living with risk

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Paper presented at the New Zealand Association of Gerontology's 11th National Conference on Ageing, 17-19 April 2002, Auckland.

Maintaining mobility has been identified as a health promoting behaviour for older people. Walking for several miles and engaging in aerobic activities has been demonstrated amongst elders and may be a continuation of mid-life activities. A group of nine older women, living in their own homes in New Zealand, have also identified exercise to be an important way of promoting their health. They make themselves exercise regularly and include the use of their walking frames and crutches in their physical activities.

The apparent benefits of maintaining and promoting physical exercise however have to be weighed up and balanced by the element of risk. These participants described the potential negative effects on their health, well-being and independence if the risk did not come off and if they fell. Tension is generated for these women who must live with the consequences of health promotion through physical activity versus potential damage to health through physical activity. They live with this risk each day.

Health promoting practices of women over the chronological age of 75 years

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Paper presented at the AUT conference 'Health Policy, Practice and Research in the 21st Century – Making a Difference' 6-9 May 2002, Auckland.

Health promotion for older people is an important issue as New Zealand faces increasing future challenges from the predicted rise in numbers of older people who will live longer lives. The feminisation of this trend is noted as women continue to live longer than men. The challenges will be multiple and include economic as well as personal life satisfaction issues.

The health promoting practices of nine older women in New Zealand will be described. These women participants were aged over 75 years, and all lived with support systems in their own homes. They promoted their health in multiple and specific personal ways. They identified that nutrition, promoting mental and physical activity, and the careful taking of medications were measures that promote their health. They also acknowledged the role of genetic and environmental factors in their health. These women articulate that their health is important and worthy of their efforts to promote it.

Public Image and Media Representation of Nursing

Mary Wade
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Paper presented at the College of Nurses Aotearoa (NZ) Annual Conference "We are able and artful nurses" 19-20 September, 2002, Nelson.

Yes...we are able and artful nurses. Nursing is also the most highly respected profession. However, highly qualified and experienced nurses are leaving nursing because they feel undervalued; tired of the low status and lack of recognition and reward. Nursing underpins the health-care system and without nurses there is no health care. It is nurses who are there 24 hours a day, seven days a week, caring for the physical, mental, and emotional needs of patients'. It is nurses who identify patients' unmet needs and put in place action to ensure medication or treatment orders are appropriate.

Recent publicity, relating to the industrial action taken by nurses, demonstrates there is a lack of public understanding and a distorted media representation of how and why nursing is indispensable to health-care. This paper explores the subordinated subject positions that nurses' employ, the silence/silencing that is overtly and covertly enforced to keep nurses powerless and oppressed, and the discursive practices which need to change, to enable the nursing voice to be more appropriately represented in health care.

Midlife Women, physical activity and a health-promoting discursive field

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Paper presented at the AUT conference 'Health Policy, Practice and Research in the 21st Century – Making a Difference' 6-9 May 2002, Auckland.

Women of all ages are being urged to become physically active to gain health benefits. Such activity is overwhelmingly portrayed by health professionals as being a positive health promotion behaviour. However for one group of midlife women such activity was experienced as positive yet problematic, embedded as it was within specific cultural spaces. A feminist and post-modern perspective underpinned a nursing research study that illuminated the complexity inherent in the maintenance of physical activity for this particular group.

Three discourses of physical activity emerged from the analysis, disease prevention, health and well-being and 'the body beautiful'. Whilst each discourse had resonance with currently competing health promoting and populist discourses, the dominant discourse in the field, bio-medicine tended to permeate. Intertwined in each were tensions, which emanate from being a midlife women living in a gendered society preoccupied with youthful, slim and attractive bodies.

This paper will offer one understanding of the three emergent discourses, the women's experiences of being physically active and nurses' positions within in this discursive field. It is suggested nurses encouraging women to be physically active need to consider each women's reality and cultural space.

POEM

*Rebecca Bavrell
Bachelor of Nursing student
Christchurch Polytechnic Institute of Technology*

Dear diary, how are you today?
Better than I am, I pray.
I'm 16, with no boy friend or job,
And I am the most terrible slob
Doing things that teenagers do
Like smoking, and parties, drugs too
I've become so incredibly lazy
But my parents, they think I'm crazy!!
They made me go see a shrink,
Who said with a smile and a wink,
"Dear girl, I think you are mad"!!
I said, "rubbish, I'm just a bit sad,
I'm fine," I said, "Just plain dandy".
As he handed out medication like candy.
So now I'm back in my room,
Shut away like some old fashioned loon
My parents, well I can see their relief,
They think that's the end of the grief,
But I have a secret you see,
Something they don' know about
I didn't tell them about the voices inside,
That are making me incredibly tired
I wish that I could say
That they tell me such nice things each day
Like "Hi there, lying on your bed
How lucky we are to be in your head
What a wonderful person you are
The best one around near or far"
But alas, that isn't true,
They tell me bad things to do
I am feeling so terribly tired
Trying to fight these voices inside
So as I write my diary tonight,
I'm ready to give up the fight
These voices, they wish I was dead,
So perhaps I should do what they said.

**Health Information New Zealand 2002 Conference:
'Keeping your finger on the pulse of Health Information
Technology in New Zealand'
8-10 August 2002, Auckland**

*Elizabeth Hanley
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This inaugural conference for HINZ was attended by 120 delegates from throughout New Zealand, Australia, USA, Switzerland, UK, and Germany. The majority of delegates were people involved in developing Health Information Technology (IT) programmes and the coding of data there was a small core group of nurses who were previously active in the now disestablished Nursing Information New Zealand.

The conference opened with Mike Rillstone, the Chief IT advisor to the Ministry of Health, who described the NZ national health IT strategy and proposed a new model for health information management. It was sobering to hear that New Zealand currently invests \$4-6 million whereas Australia commits \$AUD37 million per annum. He described the building blocks for development of health IT to include standards grounded on real health care issues with more datasets being developed. There is still a need for standardised coding for primary health care, laboratory results and outpatient information. Other building blocks included further development of the Health Intranet, relationships between providers, and IT architecture.

Ray Delaney from New Zealand Health Information Services focussed on the Health Information Management and Technology Plan, the Wave project, with particular reference to the priorities for 2002. These are the Health Intranet, the Health Practitioner Index, and the National Immunisation register. Several of the international speakers focussed on Coding of health information using HL7 and XML. I now have a better understanding of these concepts and where they fit into the health IT framework. I am thankful I had some programming knowledge.

The concurrent sessions I chose to attend were more clinically and epidemiologically oriented and gave interesting views on experiences with IT in a range of health situations. We heard about hepatitis screening in Auckland, the national Children's Cancer register, general practice issues, educational models and the use of personal digital assistants (PDA's) in nursing education. It was interesting to hear how UNITEC have progressed with their pilot of using PDA's with students in clinical practice.

The conference was a valuable place for networking with other nurses and to attend the HINZ annual general meeting. It is proposed that next year's conference will have a nursing strand in the concurrent sessions. The coding orientation this year was to promote the HL7 and New Zealand Health Users Group annual general meetings.

Colorado Mountain College Conference: My Experience

*Frances Pooley
Bachelor of Nursing Student
Christchurch Polytechnic Institute of Technology*

I was privileged to attend a Global Leadership Conference at Colorado Mountain College in May this year, with another nursing student, Frances MacDonald. Attending the conference was an experience that I will never forget and I felt honoured to participate. The conference was established to provide students with the opportunity to prepare for the global workplace.

Frances and I were too excited to sleep as we flew twelve and a half hours from Auckland, landing briefly in Los Angeles before flying to Denver. Los Angeles airport was so huge we had to catch a bus from one terminal to the other, and in Denver we caught a train to collect our luggage. We were unaware that our watches had to be put forward an hour and unfortunately missed our bus to Denver town. We were supposed to arrive to Glenwood Springs at 10pm but having missed our bus we arrived at 2am, and missed our ride to the campus. We found ourselves stuck in the middle of America not knowing what to do however, a passing policeman escorted us to a nearby motel. After this strange start, we were picked up the following morning and taken to Colorado Mountain College and shown to our rooms, where I discovered my room mate was from Nebraska.

Tuesday, May 21, 2002: Frances and I met the 11 other participants. There were two from New Zealand, three from Australia, one from Mexico and five from America. At the program orientation, we introduced ourselves, met Michael Wigham, the program director and discovered we had an accent!

After orientation including a trip around Glenwood Springs, we headed back to the campus and already we had homework in the form of a Leadership Development survey. Before attending the conference we had to have completed two assignments. The first one was a book review of Roger Fisher's book '*Getting to Yes*' for negotiation and conflict resolution. The second assignment was a reflective paper to understand attributes and actions of two leaders past and present who we feel are effective leaders and who inspire us. The two leaders I chose were Irihapeti Ramsden and Apirana Ngata.

During the conference we studied subjects and undertook many activities including:

- Leadership and art, Developing your personal leadership style
- High performing teams in theory and practice
- Challenge course
- Multiculturalism in the global economy
- Rock climbing
- Conflict transformation
- Leadership panel
- River rafting: "Putting the "T" in team"
- Mountain hikes
- River rafting

These activities were sponsored by the Post-Secondary International Network (PIN). The theoretical foundations and experimental activities enabled us to explore leadership, multiculturalism, teamwork, negotiation and conflict resolution skills. It was an excellent learning opportunity to network with the faculty and students from around the world.

Our journey home was an adventure also, as we had made the best of friends and were so involved with saying our goodbyes that we missed our bus to the airport. One of our new friends had to drive us to catch the bus; it was like a movie. Frances and I could not speak to each other on the bus as we couldn't believe that this experience was over and we were on our way home. After travel delays and luggage left behind we were pleased to finally arrive home. While I am pleased to be home, I intend to do some more travel and hope to return to America before too long. The conference was a great learning experience for us both.

Primary Focus: The future of Primary Health Care conference 30-31 May 2002, Wellington

*Judy Yarwood
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Wellington played host to around 700 delegates, health professionals, policy people, and researchers at the Ministry of Health's Primary Focus: The future of Primary Health Care conference in May this year. Many nurses from a variety of backgrounds were in attendance and were hopefully heartened by the sentiments of the many speakers. Opened by Annette King, the Minister of Health urged delegates to move beyond the rhetoric of Primary Health Care, (PHC) and the conference programme quickly moved to the workshops, free standing presentations, vital networking and chat, and four prestigious keynote speakers, two of whom were two nurses. Professor Anne McMurray, Dean of Faculty of Nursing and Health at Queensland's Griffith University and Professor Shirley Smoyak, from the Department of Urban Studies and Community health at Rutgers University in New Jersey.

Both presentations were highlights of this gathering, with Professor Smoyak providing a humorous, pragmatic and provocative overview of how health systems embrace change. She talked about "who owns what?" and "who has the knowledge and/or the skills to do what?" and sees these questions as the beginning of a dialogue for health professionals as they work towards relating and collaboration. A proponent of PHC, Professor Anne McMurray is also the Australian International Council of Nurses expert advisor on PHC and author of a recent and well respected text, *Community health and Wellness: A socio-ecological approach*. She gave a wider perspective of global health incorporating the four global challenges identified by the World Health Organisation; reducing the burden of the poor health/poverty nexus, prevent mortality related to environmental factors and unhealthy lifestyles, increase effectiveness of health systems to reduce health inequalities and to expand health knowledge base of countries. To build a sense of renewal in community life, underpinned by PHC, requires health professionals, especially nurses, to foster a vision which incorporates these four challenges, Professor McMurray argued.

Many of concurrent sessions provided an insight into the amount of inspirational work nurses are currently undertaking in the arena of PHC, including Plunket initiatives, community based cardiac and diabetes services, health education and promotion, PHC nurse led clinics, sexual health, mental health and neighbourhood based service innovations. It was gratifying also to see nurses working collaboratively with other health professionals to provide health services in communities where there are still huge unmet needs. The recently convened Minister of Health's Expert Nursing Advisory Group gave an overview of their considerations of the opportunities the PHC strategy presents to nurses working within this arena. There are challenges aplenty for this group including leadership, governance, postgraduate education programmes and the newly developed nurse practitioner roles.

Whilst some may have seen this conference as an opportunity for the Ministry to sell the PHC strategy and hasten the development of Primary Health Organisation's, it was also a great chance for health professionals committed to PHC to debate, discuss and exchange ideas thus somehow smoothing the long and windy road ahead.

**Australian and New Zealand College of Mental Health Nurses
(ANZCMHN) Conference,
October 15-18 2002, Sydney**

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The 28th ANZCMHN conference was held in impressive surroundings in the Convention Centre on the edge of the picturesque Darling Harbour, Sydney. As is commonplace, the conference mostly comprised of a number of concurrent presentations organised into thematic areas. A difference this year appeared to be an extra emphasis on practice. Whilst laudable, this perhaps inadvertently, exposed practices of dubious quality as well as exemplifying exciting innovations.

The contrast in the quality of practices was highlighted by the differences between areas providing inpatient care. Some presenters demonstrated that although innovation of practice can be necessary, contemporaneous “traditional” care undertaken by reflective practitioners is still important to service users. An example of such care was provided by one English nurse researcher who had undertaken an ethnographic study in an ICU environment. Such a methodological approach had allowed her to find out viewpoints of both staff and service users, whilst contextualising the reasons for such care. Such an approach allowed for pragmatic suggestions for improvements to be made within the real constraints of everyday practice, whilst acknowledging what it is that nurses do so well.

In contrast, a presentation by members of an Australian inpatient team highlighted the need for clinicians to involve service users in policy planning. The presenters described a decision to permanently lock the inpatient unit in the face of escalating costs of close observation of inpatients. Unfortunately this presentation was delivered in a way that merely proclaimed the benefits of the intervention, without providing a vigorous critique of the literature, nor examining the effects of such actions on others. Whilst disappointing, these types of session at least (inadvertently) provide a reminder to clinicians that reflection on practice and openness to critique from others is essential when planning changes to practice.

The above session also highlighted the benefits of the involvement of service users in conferences. These persons were able to both provide a theoretical counterbalance to arguments, while offering an insight into the effects of actions.

Overall, the conference was quite mixed in terms of quality. Like other conferences though, the most benefit was likely provided by the opportunity to network with others, share ideas on good practice, and vigorously debate those that are less desirable.