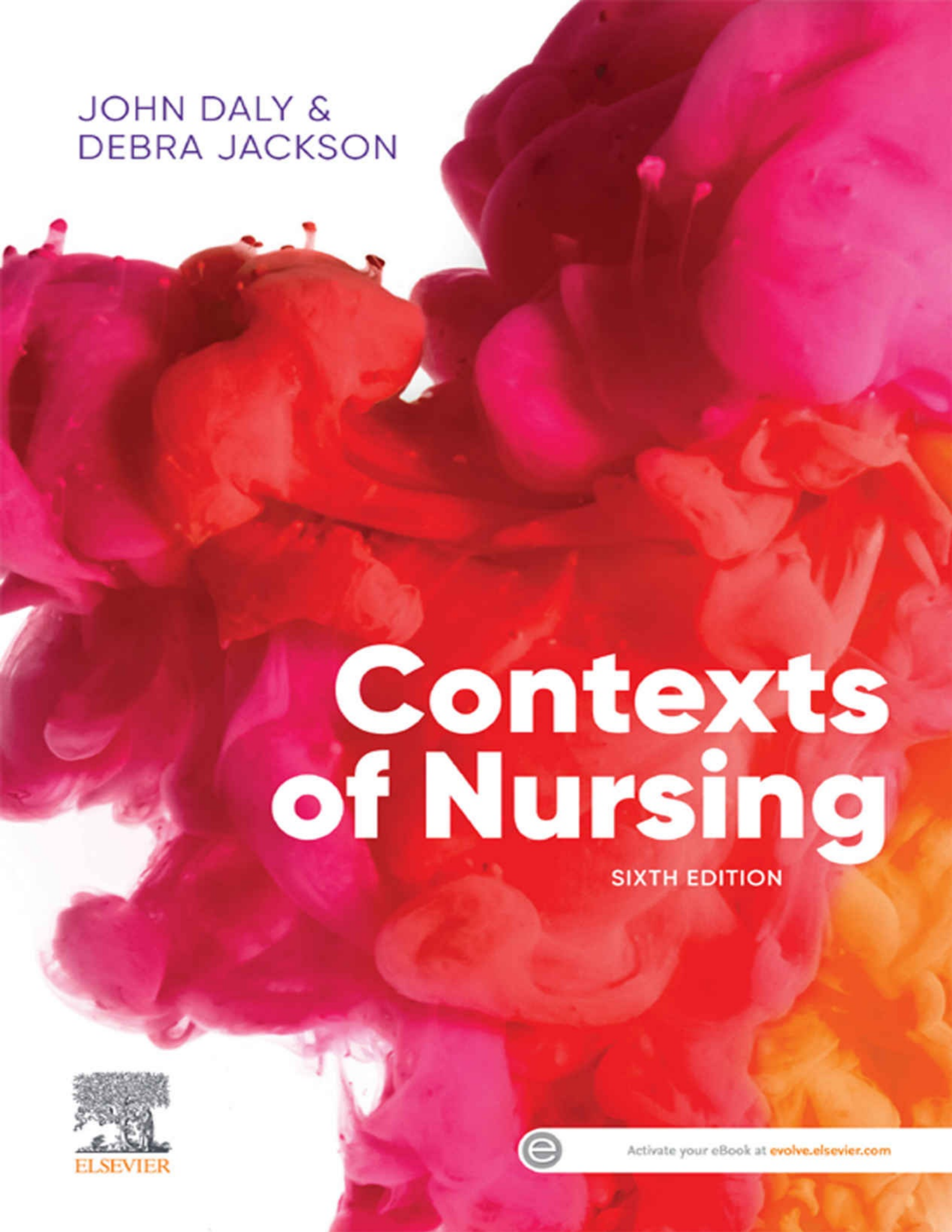
JOHN DALY &
DEBRA JACKSON

Contexts of Nursing

SIXTH EDITION



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Contexts of Nursing: An INTRODUCTION

SIXTH EDITION

JOHN DALY

DEBRA JACKSON

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Tower 1, 475 Victoria Avenue, Chatswood, NSW 2067

ISBN: 978-0-7295-4356-9

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National Library of Australia Cataloguing-in-Publication Data

A catalogue record for this
book is available from the
National Library of Australia

Content Strategist: Elizabeth Houston
Content Project Manager: Fariha Nadeem
Copy edited by Jo Crichton
Proofread by Annabel Adair
Cover by Georgette Hall
Index by Innodata Indexing
Typeset by New Best-set Typesetters Ltd
Printed in China by Markono Print Media Pte Ltd
Last digit is the print number: 9 8 7 6 5 4 3 2 1

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PREFACE

Welcome to the sixth edition of *Contexts of Nursing*. There has never been a more exciting time to be a nurse! As we write this preface in 2020, the year designated by the Seventy-second World Health Assembly as the International Year of the Nurse and the Midwife; the world is gripped by a deadly pandemic, and nurses everywhere are in active service in efforts to combat COVID-19 (Daly et al 2020). To mark this important year, on World Health Day, the World Health Organization (WHO) released the *State of the World's Nursing 2020* report (WHO, 2020) providing important information about the global nursing workforce, and a persuasive argument for the need for appropriate investment to fully develop this workforce (Daly et al 2020).

We hope you, the reader, will find this book useful and informative. As with the previous editions, this volume introduces students to the theory, language and scholarship of nursing and healthcare. Since we prepared the first edition, our major objective has been (and remains) to provide a comprehensive coverage of key ideas underpinning the practice of contemporary nursing. This book is a collection of views and voices; consequently, the chapters are not all identical in nature. This reflects our position that it is important that students/readers engage with various (and sometimes conflicting) views to challenge and extend them. This is a good thing, and will hold students in good stead for the future, as the discipline and profession of nursing continues to evolve, mature and develop within Australia and New Zealand and globally. Nursing knowledge and its foundational elements are explored and considered in relation to professional nursing practice and the context of healthcare.

We have explained previously why the notion of 'contexts' has appeal for us in conceptualising nursing knowledge as a fabric composed of theoretical threads. This 'knowledge-as-fabric' metaphor provides access to a number of other related ideas, such as weaving and tapestry. Several new threads have been woven into the fabric of nursing knowledge presented in this work. Selection of these topics was based on extensive consultation with nurses who found previous editions useful in undergraduate and graduate courses and in their educational development and practice.

Our emphasis on pedagogic strength and accessibility, and the use of reflective questions and exercises to stimulate critical thinking and learning, has been maintained. In this new edition, a number of new strategies have been incorporated to facilitate deeper personal reflection by the learner and teacher. Placing these reflections at pertinent points within the chapters breaks up the content and allows the reader to stop and consider what has been learned so far. Stories are used by a number of contributors as case study examples to further contextualise topics for students. Chapters are structured to facilitate greater internalisation of content by the reader.

We would like to acknowledge our co-editor in previous issues, Sandra Speedy. We thank Libby Houston, Fariha Nadeem, Jo Crichton, and the entire team at Elsevier, for

their ongoing enthusiasm, encouragement, support and assistance in the preparation and production of this new edition. Most of all, we thank our contributors, who have risen again to the challenge of developing engaging, scholarly and learning- and teaching-oriented work to stimulate reflection, discussion and debate.

John Daly and Debra Jackson

Sydney, June 2020.

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CHAPTER 1: PRESENTING NURSING … A CAREER FOR LIFE

John Daly and Debra Jackson

KEY WORDS

career; critical; perspectives; lifelong learning; nursing; stereotypes

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- list some of the myths, legends and stereotypes that surround nursing;
- arrive at a personal beginning definition of nursing;
- understand their passion for nursing;
- discuss some of the choices that a nursing degree offers for graduates;
- describe the meaning of the term 'professional conduct'.

Why nursing?

Nursing is a unique and wonderful career choice. It is a curious mix of technology and myth, of science and art, of reality and romance. It blends the concrete and the abstract. It combines thinking and doing, 'being with' and 'doing for'. Nurses have privileged access to people's homes and share some of the most precious and highly intimate moments in people's lives—moments that remain hidden from most other people and professions. Nurses witness birth and death, and just about everything in between. Nurses share in people's most difficult moments of suffering and pain, and also bear witness to times of great joy and happiness. Because of the special place in society that nurses hold, nurses enjoy a high level of community trust. Indeed, in Australia and New Zealand, nurses continually rank very highly in surveys of public confidence.

Nursing can be a career for life. A degree in nursing provides a foundation for lifelong learning. It is the entry requirement to a fulfilling career, to a range of postgraduate courses in areas as diverse as paediatrics, midwifery, cancer care, community nursing, women's health, nurse education and nursing research. Age and

experience are valued in nursing. Unlike many other professions and career choices in which people experience increasing difficulty in obtaining work as they get older, nurses can remain productively employed until retirement, and even post-retirement. Experience and expertise are highly valued in nursing. The concept of expertise in nursing is indeed an interesting one. There is debate and discussion in the literature about what comprises expertise in nursing (Hutchinson et al 2016) and we expect this debate to continue as alternate models of entry into nursing are developed. Career interruption because of family responsibilities (or other reasons) can be extremely disadvantaging in some professions, but many nurses have effectively blended very successful careers with raising families. Nursing opens many doors. Internationally, Australian and New Zealand registered nurses are well respected and are able to gain registration as a nurse in many other countries.

In this opening chapter, we aim to share what captured us and created our passion and enthusiasm for the wonderful career that is nursing—the passion and enthusiasm that has sustained and carried us successfully through our nursing careers. We also describe the different types and levels of nurse in Australia and New Zealand, and aim to introduce you to some of the ideas of interest to nurses and nursing, many of which are discussed in more detail in subsequent chapters of this book.

REFLECTION

What are the main reasons you have chosen a career in nursing?

Nursing: myths, legends and stereotypes

Philosophically, nursing has gone through a number of historical transitions. Asceticism, arising from our origins in religion and the army, then romanticism, followed by humanism. Perhaps more than any other professional group, nursing and nurses are the subject of myth and popular belief; there are also many romantic connotations. Certain of these myths and beliefs are almost folkloric, yet they strongly influence the ways in which nurses are perceived by the general public and also in the ways that nurses see themselves. Through the media, nursing is often portrayed as a dramatic, exciting, glamorous and romantic activity, with nurses frequently represented in the role of handmaiden/helper to medical doctors. Several of the almost legendary attributes that surround nursing are derived from myths about Florence Nightingale and her work in the Crimean War. For example, the romantic notion of the 'angel of mercy', the quiet, modest and self-effacing woman who, with a religious-like fervour, would tirelessly and uncomplainingly nurse the ill and injured back to full strength, and the image of the 'lady with the lamp' fearlessly working at the frontline of a war zone, and instilling calm, peace and tranquillity where only chaos and suffering had reigned, have become enduring and mythologised popular images of the nurse (Bostridge 2008, Bridges 2006).

Because of her continuing allure, much of Nightingale's life has been reconstructed and, in the process, subject to various forms of poetic licence. An excellent example of this poetic licence is explored by Jones (1988) in her critical examination of *The White*

Angel, a motion picture released in 1936, which purported to be a biographical representation of the life of Florence Nightingale. On its release, this film was widely acclaimed, both within and outside the nursing profession, with influential professional nursing journals promoting the movie as 'a good educational picture', and commending it to the nursing profession, 'especially those concerned with information and education' (Jones 1988:222). However, although the movie was widely accepted as factual, even by the nursing community, Jones (1988) proposes that the screenplay contained a series of key errors, which served to trivialise major events in the life of Nightingale, and reinforced the myth that her decision to become a nurse was made in the manner of a religious calling.

> *[S]he is dressed in white, thus fulfilling the image of the title [The White Angel], but the image does more than just show Nightingale in white. Her dress and veil are like a bridal gown and veil in style as well as color. The association of white with virginity and purity is important, as is the bridal association. At the same time she announces her decision to be a nurse, Nightingale announces to her parents that she will never marry. Because she is visually presented as a bride at the same time that she rejects marriage, the subliminal message is that her marriage is to her profession, just as a nun's marriage is to Christ.*
>
> *(JONES 1988:225–226).*

However, notwithstanding the influence of myth and legend, nursing does have a noble history, and there are many stories of the fortitude, bravery and courage shown by Australian and New Zealand nurses in wartime and other times of community hardship (e.g. Fealy et al 2015, Siers 2013). Nursing is endlessly fascinating to many people and this is reflected in the number of television shows, novels and movies that feature nursing and nurses as a major component. There is not the same level of interest in bank workers or bus drivers or beauty therapists, for example. Nursing is ripe with imagery. Many of the images associated with nursing are seemingly at odds with one another, yet all may be conjured up by the word 'nurse'. Images of selflessness, kindness, compassion and dedication, hard work, long hours, submission and low pay are among the things that come to mind for some people when they think of nursing (Creina & Meadus 2008, McDonald 2012, Maher & Lindsay 2008). But though nursing has current or historical elements of all these things, there is so much more to nursing than these portray. Chapter 2 in this book provides a comprehensive overview of nursing history which extends the reader's understanding of the rich and varied history of nursing.

Nursing and nurses are subject to various entrenched stereotypes (Girvin 2015, Girvin et al 2016, McDonald 2012), and some of these are at least partly derived from the myth that surrounds nursing. In what has become a classic work, Kalisch and colleagues (1983) identified some major ways that nursing and nurses were stereotyped, and though this work was undertaken in the United States more than two decades ago, it remains relevant to nurses today. The media and popular literature also tend to present nurses as having stereotyped personal characteristics such as youthfulness, femaleness,

purity and naivety, altruism and idealism, compliance and diminutive stature and 'good character' (Fealy et al 2015, Fink 2013). Nurses are also credited with having certain qualities and virtues that are grounded in romanticism (Mee 2006, National Nursing and Nursing Education Taskforce N3ET 2006, Summers 2010). De Vries and colleagues (1995), in their study of images of nurses as portrayed in popular medical romances, found that nurses are almost always represented as youthful, pure, virginal, kind, petite, beautiful, subservient, sensitive, considerate, competent and able females, paired in romantic relationships with male physicians. In addition to these personal characteristics, the heroines of these stories are typically presented as Caucasian, with blonde hair and green or blue eyes. They have also been portrayed and represented as being emotional and hence not to be taken seriously (Ceci 2004). Writing more recently, Miller (2015) found that the genre had expanded, and in addition to nurses, the heroines now included midwives and allied health professionals.

Darbyshire (1995) in his exploration of the depiction of Nurse Ratched in the popular film *One Flew Over the Cuckoo's Nest*, discusses a counter image of nursing—the battleaxe/torturer. Unlike the nurses found in the medical romance genre, Nurse Ratched is not petite or subservient, nor is she acquiescent or particularly beautiful. Hunter (1988), in her discussion of the book upon which the film is based, proposes that the Nurse Ratched character is but one example of misogynistic literary tendencies which, she argues, frequently satirically portray the battleaxe/torturer/oppressor nurse as female, and the tender, gentle carer nurse figure as male. Hunter (1988) supports this notion by exploring the images evoked in Tolstoy's description of the gentle hero Gerasim (*The Death of Ivan Ilyich,* 1886) and Whitman's poem 'The wound dresser' (*Leaves of Grass,* 1891), and comparing them with those evoked by Kesey's Nurse Ratched (*One Flew Over the Cuckoo's Nest*, 1962). The reader may wish to explore these historical sources to gain further insights.

REFLECTION

Consider the popular stereotypes of nurses. How many can you identify? Did any of these stereotypes influence your decision to become a nurse?

Though we still see nurses portrayed in various stereotypical and sometimes highly sexualised ways, which is exemplified in the myth of 'nurse as whore', these stereotypes coexist with some of the noble and romantic images of nursing. Failure to challenge these stereotypes is dangerous for nurses and nursing (Summers & Summers 2014) and various stereotypes give the nurse the status of a worker–handmaiden rather than a health professional (Campbell 2013, Kelly et al 2011, Stokowski 2010). Stereotypes of this nature also help to perpetuate an anti-intellectual bias against nursing, which is manifest in the view that good nurses are primarily practical people, rather than highly educated health professionals. Coexisting with the romantic myths and stereotypes surrounding nursing is the reality of nursing. This reality is that nurses become acquainted with the visceral and raw aspects of humanity that are usually hidden from the world, because of the illness, the incapacity, the frailty, the disability or other needs of those who are the recipients of nursing care. Nursing provides opportunities for

human connectedness and growth that few other careers can offer. Values of humanism in nursing are enacted and embodied through the commitment to compassion and respectful relationships that are sensitive to the belief systems and cultural practices of others.

It is important to recognise that the concept of 'nurse' is socially constructed, and that nurses may want to believe in their power and control, but the broader societal context situates nurses in a much more fragile position. Nursing exists within a healthcare system, bound by authority and power that does not generally lie with nurses. Some of the effects of this on nursing can be found later in this book in Chapter 11.

How to define nursing?

The urge to define nursing has attracted the attention of nurse scholars for a number of years. While defining a nurse is relatively simple, as you will see as you read further in this chapter, nursing itself has proved somewhat more challenging to define. There is a wide variation internationally in the definitions of nursing roles. Though you can probably describe what you think nursing is, the nature and breadth of activities that comprise nursing have contributed to the difficulties associated with defining nursing. Some definitions centre on the functions of a nurse, rather than offering an intrinsic definition of nursing. In a now historical piece of writing which has endured, Henderson produced such a definition of nursing:

> *The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he [sic] would perform unaided if he [sic] had the necessary strength, will or knowledge. And to do this in such a way as to help him [sic] gain independence as rapidly as possible.*
>
> *(HENDERSON, 1964)*

What needs to be noted in passing is the sexist language that continues to be used when referring to nursing. Language is not a neutral information-carrying vehicle, but creates meaning; this meaning changes over time, which makes language very powerful (Erhlich et al 2014); its importance cannot be underestimated. David (2000) provided a challenging analysis of how nurses collude with oppressors by uncritically accepting outsiders' social construction of nurses and nursing, suggesting that nurses need to socially construct themselves and their context in order to regain their identity and power. Stanley (2010) notes that a contributing factor to lateral violence is gender; the socialisation of girls and gendered health organisations in which the minority gender has the power to help to create an environment that tolerates lateral violence. Added to this, a recent EOWA (Equal Opportunity for Women in the Workplace Agency) report, 'Gender Pay Gap Statistics', found that the gender pay gap in the healthcare and social assistance sector increased by 4% between 2011 and 2012, due to the stereotype that these professions are viewed as women's work, underpaid and undervalued (Australian Ageing Agenda 2012). In 2013–14, the gender pay gap was 16.4%, and in 2014–15 it was 18%. In New Zealand, there was a gender pay gap of 9.9% in 2014, while

in 2015 it was 11.8% (Statistics New Zealand 2016, Workplace Gender Equality Agency 2015).

The complexities and difficulties associated with defining nursing mean that some definitions may seem cumbersome and quite ambiguous. But remember that this is more a reflection of the complex nature of nursing than any lack of clarity on behalf of those who have proffered a definition. The International Council of Nurses (ICN), a coalition of nurses' associations that represents nurses in more than 120 countries, has captured some of the complexities in its definition:

> *Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*
>
> *(INTERNATIONAL COUNCIL OF NURSES (ICN) N.D.)*

REFLECTION

1. Why do you think nursing has proved difficult to define?

2. How is nursing defined in your own jurisdiction? Consider this definition in relation to one from another jurisdiction, region or country and consider any differences or similarities.

Choosing nursing

Nursing was a gender choice given the societal and historical context of the time (early 1960s and 1970s). It was certainly viewed as an appropriate career choice for females, but also offered potential for achievement, growth and development. It was also a profession that attracted people motivated by altruism and the desire to make a difference to people suffering because of illness and disadvantage. Indeed, this is still a significant motivator of people who choose nursing today. Since the 1970s nursing has made stronger claims to a focus on health promotion, and this now has greater emphasis in construction of nursing knowledge and in conceptualisation of practice. But further to that, there was an overriding quest for understanding and caring for people. This was demonstrated in an egalitarian approach that proved to be unacceptable in nursing at the time (1963–77), when spending time with and caring about patients was viewed as naive and misguided. Such a view denied empathy and concern, and existed through the 1980s and 1990s (McVicar 2003). The concept of nurses distancing themselves from their patients has long since been superseded by recognition of the importance of the nurse–patient relationship or the 'therapeutic alliance' (Elvins & Green 2008, Pullen & Mathias 2010). The therapeutic relationships that occur between nurses and patients, clients and families mean that nurses have to

care for their emotional wellbeing. The 'emotional labour' that is expended on these relationships can result in compassion fatigue if self-protective measures are not in place (Yoder 2010) and is an important concept for nurses to be fully aware of, since it can take a heavy toll on nursing performance. Readers interested in more extensive coverage of emotional labour are referred to Chapter 3 of this text.

Nursing: what sustains us?

One of the most sustaining things about nursing and being a nurse is the opportunity to contribute a perspective that is informed by feminism. A feminist perspective is concerned with gender, power relations, patriarchy and hegemony in society, emphasising gender as a key factor in determining perceptions of nurses and nursing (Fealy et al 2015).

Feminist theory can be used to examine power relationships in nursing and healthcare, resulting in the exposure of the 'doctor–nurse game' (Holyoake 2011, Olin 2012), and more recently in the 'health administrator–nurse game' (Gaffney et al 2012, Paynton 2009), which elaborates on how nurses can be losers in the power stakes. The issue of gender is important for nurses, and is an issue that continues to generate critical discussion in nursing, particularly in relation to the maintenance of power relations and the formation of an identity in nursing (see, for example, Center for American Nurses 2008, Tracey & Nicholl 2007).

Nurses are socialised early in their development to adopt 'appropriate' behaviours and beliefs about how to behave as professionals, and how to, as women (predominantly), 'look, talk and feel' (Hanna & Suplee 2012). Their age, gender, family and life experiences all contribute to and influence the way they perceive the power structures and dynamics of the world that is nursing work (Porter-O'Grady 2011). To be unaware of the impact of power relations and the oppression arising from these is to be locked in a cycle of relationships that serve to severely disadvantage nurses and nursing, perpetuating disunity and disempowerment (Germain & Cummings 2010).

Recognising the importance of the perceptions and experiences of nursing students with regard to nursing work, Bloom (2014) noted the consequences of overt and covert behaviours of hostility and recognised the devastating effects of these behaviours, indicating how this would impact on their future career and/or employment choices. This may have negative implications for the future of nursing (Norris 2010).

It should be noted in passing that many young women of today appear to have an uneasy relationship with feminism, and some have totally rejected its meaning for them. However, the real problem can be identified as: 'can I be who I think I am and be feminist?' (Andrist et al 2006). This confusion is understandable, since young women are unclear about what feminism requires of them (and does not require of them). For example, can they still like fashion, have boyfriends, be forthright and self-determining and be who they want to be? They may think of feminism as telling them what they cannot do, rather than as a philosophy that *shows them the potential for what they can do* and hence what they can contribute. This suggests that young women may be developing greater clarity about this situation. For example, scholars have suggested that the emphasis on feminism has shifted to a more global activity and social

perspective (Hemmings 2012).

A natural consequence of a feminist perspective was an interest in the theory and practice of feminist research, which demanded refocusing on the experiences of women, as historically much research was focused on men and done by men. This required some fortitude and commitment, because at that time there was scepticism and ridicule directed towards those who advocated its usage, particularly from researchers who promoted a 'hard science' perspective as the only valid and reliable form of research. However, research that is informed by feminist (and other postmodern) perspectives is now more readily accepted, generating important knowledge.

A sustaining factor within a nursing career is the opportunity to provide leadership in as many ways as possible, be it research, management or practice. Effective leadership requires particular attributes, such as high-level communication skills, awareness of one's beliefs, values, attitudes and emotions, respect for others, commitment, passion, flexibility and adaptability (Daly et al 2015).

Transformational leadership is dominant in the nursing literature and though quite uncritically embraced by nursing (Hutchinson & Jackson 2012), it is said that such leaders are able to create shared visions, act as role models, inspire, motivate, intellectually stimulate and mentor others (Reinhardt 2004). In many ways, 'leadership is a process of drawing out rather than putting in' (Kitson 2004:211). This implicitly suggests that everyone has a responsibility to exercise leadership qualities. Acknowledging that nursing has many talented participants, Kitson implores us to desist from 'eating our young', or cutting our leaders down ('tall poppy syndrome'), and suggests that, as we work with patients, families, colleagues and managers, we:

> *… draw out our vision, our values and beliefs about nursing; our notion of service; our understanding of our own humanity and our ability to face pain, suffering, anxiety, anger and all the other human emotions that nurses face on a daily basis.*
>
> *(KITSON 2004:211)*

By developing these understandings, we can understand and accept ourselves, and see beyond to the dysfunctionality of organisations and workplaces in order to reform them. This requires nurse leaders to be political, astute (Marshall 2011) and acquainted with the current literature, which stresses the issues of trust and employee engagement for optimum leader performance (Clarke 2011). Clarke (2011) highlights that 'trust based on the motives and integrity of others, and trust based on their perceived competence and ability' are also essential characteristics (2011:1). These are all the skills that nurses at every level of the profession have, to a greater or lesser degree, which provide them with opportunities to assume leadership roles, whatever the level and location of their work.

Women have specific leadership skills that can be harnessed. The research literature suggests that, in general, successful women leaders value interconnectedness, inclusivity and relationships, whereas male leaders value competition, dominance, ambition, aggression and decisiveness (Garcia-Retamero & Lopez-Zafra 2006). In focusing on leadership in nursing, Garcia-Retamero and Lopez-Zafra identified a warm

demeanour, personal and professional interest in followers, nurturing behaviour, promotion of growth in others and the use of humour and interpersonal talk as some of the characteristics that make for successful nurse leadership.

Over the years of our own nursing careers we have witnessed many changes—from changes in how students are prepared for registration as nurses, through to changes to the environment in which nurses work. Nurses work in climates of continual change, and are challenged by the demands of ageing and increasingly complex clients. One major change is the increased realisation of the importance of research; the importance of both generating and drawing on robust evidence to underpin our practice as professional nurses. It is essential that all nursing care is informed by high-quality evidence. There are many debates in the current literature about the importance of evidence (rather than tradition) informing practice (Hutchinson & Jackson 2016). In addition to these challenges, nursing is currently making attempts to address an international widespread shortage of experienced nurses, particularly specialist nurses (American Association of Colleges of Nursing 2012). Recruitment and retention issues have contributed to an ageing nursing workforce, increasing casualisation of that workforce and increasing international recruitment (Center for American Nurses 2008, Norris 2010).

Furthermore, issues including bullying, abuse and violence, professional autonomy, imposed organisational change, occupational health and safety issues and constant restructuring have been associated with difficulties in retaining a viable nursing workforce in that they contribute to a working environment that can be experienced as hostile and difficult (Hutchinson et al 2008, Rodwell & Demir 2012). The Center for American Nurses supports the 'development of zero tolerance for abuse in the workplace' as a strategy to remove disruptive behaviour altogether (2008:4), since such behaviours are not conducive to a culture of safety (Hutchinson & Jackson 2012). If nursing is to continue to be an attractive profession on which satisfying and rewarding careers can be built, it must embrace cultural change to 'eliminate the effects of disruptive behaviour including lateral violence and bullying at the personal, organizational, national and international levels' (Center for American Nurses 2008:5).

REFLECTION

1. What has been your experience, so far, of nursing?

2. What motivated you to become a nurse?

3. What now sustains you?

Types of nurse in Australia and New Zealand

There are a number of entry points into nursing. In Australia and New Zealand, the title 'nurse' refers to someone who is recognised as such by duly authorised registering authorities. Nurses belong to a regulated professional group that is responsible to the

community it serves for supplying healthcare to a constantly high standard, through the maintenance of professional standards and personal integrity. In both New Zealand and Australia, nurses are required to have completed approved educational programs through which course participants achieve predetermined standards and competencies in order to become eligible to apply for registration or enrolment as a nurse. In Australia, courses that prepare enrolled or registered nurses must be assessed and approved by the Australian Health Practitioner Regulation Agency (AHPRA) (which supports the Nursing & Midwifery Board of Australia [NMBA]) and the Australian Nursing and Midwifery Accreditation Council (ANMAC). Recently the NMBA moved away from referring to competency standards for practice which are now known as the NMBA Standards for Practice (NMBA 2016). In Australia, new enrolled nurse Standards for Practice were introduced from January 2016, and new Registered Nurse Standards for Practice from 1 June 2016. Standards for practice are subject to review at intervals to ensure high professional standards and to ensure that the public are receiving contemporary care and support. In Australia, courses that prepare graduates for registration as enrolled or registered nurses must meet AHPRA, NMBA and ANMAC standards.

In New Zealand, respective courses are guided and informed by standards set by the Nursing Council of New Zealand. Similar requirements apply in the developed world and many areas of the developing world. To explore the role, function and governance of these agencies that regulate and accredit nursing and midwifery in Australia, see:

- www.ahpra.gov.au
- www.nursingmidwiferyboard.gov.au/
- www.anmac.org.au

Detailed information on NMBA Standards for Practice for ENs and RNs can be located at the NMBA website: www.nursingmidwiferyboard.gov.au

REFLECTION

What differences are evident between the different levels of nurse in your jurisdiction?

ENROLLED NURSE

The enrolled nurse (EN) is one who has completed an approved educational course leading to enrolment with nurse-registering authorities. The EN course is of 12–18 months' duration. There are a number of career development opportunities available to ENs and these can include access to professional development courses that permit an extended role, such as medication administration. Some ENs wish to study further to complete qualifications to become registered nurses. Many universities and colleges give some recognition of prior learning to ENs, meaning that they may be able to undertake a shortened version of the Bachelor of Nursing degree.

REGISTERED NURSE

The term registered nurse (RN) refers to one who has undertaken and completed an approved program leading to nurse registration as a nurse, holds an appropriate qualification, has met all the requirements of registering authorities and whose name appears on a register of nurses in accordance with the relevant national legislation. The RN is considered to be a first-level nurse and, as such, is permitted to practise without supervision and is accountable and responsible for actions taken and decisions made.

RNs have various career progression paths and various titles, depending on where they are located (see Box 1.1), so as you enter hospitals and community health settings you will encounter RNs with varying degrees of experience. These can include clinical nurse consultants (CNCs), clinical nurse specialists (CNSs), nurse managers, nurse educators, nurse researchers and other categories of nurse.

BOX 1.1 Clinical practice settings for nurses

Nurses prastise in a wide range of health and community settings, including:

- acute hospital settings
- day surgery nursing
- daycare clinics
- residential care facilities (such as nursing homes)
- schools
- drug and alcohol nursing
- general community nursing
- specialist community nursing (such as mental health nursing)
- occupational health nursing
- general practice (or practice) nursing
- justice health (including remand centres, prisons and juvenile justice settings), and
- rural and remote area nursing.

ASSISTANT IN NURSING OR NURSE'S AIDE

The assistant in nursing (AIN) or nurse's aide is a person who carries out some nursing

duties under the direct supervision of an RN. Most often, the duties are associated with activities of daily living, such as hygiene, feeding and personal care. Many undergraduate students undertake employment as an AIN while they are studying their undergraduate degree at university.

There are various titles given to people fulfilling the AIN (or very similar) role, and these titles are applied in various locations. Some of the other titles are nurse's aide, care worker or personal care assistant. AINs (and similar workers) are known as unregulated health workers, and they do not come under the auspices of nurse-registering authorities. Rather, the RN under whose supervision they are working is accountable in the event of an adverse situation occurring.

Professional regulation and conduct

Nurses are expected to be people of integrity who conduct themselves with a high level of personal honour and veracity. It is important that members of the public feel safe in hospitals, and believe themselves to be in trustworthy and competent hands. If people do not feel safe, they would not be able to feel secure in leaving their loved ones in the care of nurses and healthcare facilities. Nursing authorities act to ensure the safety of the public by holding nurses accountable for their actions and making nurses answerable for their behaviour and any complaints that are made against them. In order to gain initial registration, nursing applicants need to demonstrate they are competent and of good character.

REFLECTION

What do you see as essential personal qualities for nurses?

Nurses are answerable to registering authorities that have the power to question nurses and suspend or remove them from the register. These same authorities can also place conditions on registration, restricting practice or, in certain circumstances, requiring a nurse to participate in educational programs. The conduct of nurses is also guided by various codes that inform professional conduct. Though these vary depending on country, they are remarkably similar in substance. This is because the values of nursing cross national and international boundaries. It is an interesting exercise to use the internet and search for the Code of Conduct that governs you in your location.

REFLECTION

What are some examples of good and poor professional conduct? If you have worked in a clinical setting, or been on a clinical placement, can you think of some from your own practice experience?

CONCLUSION

Nursing attracts people from all walks of life. Many readers of this text will be entering nursing as school leavers, but others will be mature-aged students who come to nursing with a variety of life experiences. Welcome to nursing, and congratulations on making a choice that will open many doors for you and provide you with a career for life. You may find it challenging and, possibly, not quite what you expected. But go with your passion, and believe in yourself—because you can create your life. The road you have chosen is not an easy one, but you need to believe in yourself, as we do, to succeed. We may have had a more facilitative environment, so for that we are grateful. We take this opportunity to wish you as satisfying a career in nursing as we have had.

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CHAPTER 2: VISIONING THE FUTURE BY KNOWING THE PAST

Madonna Grehan

KEY WORDS

education; history; hospitals; midwifery; nursing; regulation

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand the benefits of having a knowledge of the history of nursing;
- develop a critical understanding of received accounts of the history of nursing;
- identify the lineage of nursing and its occupational relatives;
- identify significant events that have influenced the evolution of nursing in Australia and New Zealand;
- describe aspects in nursing and midwifery that warrant historical research.

INTRODUCTION

This chapter offers a snapshot of the vast history of nursing. It briefly considers the antecedents of contemporary nursing and examines the formations of care in Australia and New Zealand that established patterns of care provision. It considers some of the historical influences on nursing, milestones in the evolution of nursing, and it raises the relationship between history and professional identity. The chapter concludes with remarks on what history can tell us about the future of nursing.

Disclaimer: Aboriginal and Torres Strait Islander people are warned that this chapter may contain images of deceased people.

History and its relevance to nursing

History, heritage, tradition and the past are concepts that may be familiar to most of us, but what is their relevance to nursing? This chapter explains why having an understanding of the history of nursing is useful for all nurses, whether working in practice, education, administration or the policy arena. An Australian historian, Graeme Davison (2000), argues that, among other things:

> *History … tells us who we are, gives us an imaginative and sympathetic insight into the lives of others, encourages a critical attitude to question social and political change, and equips us to participate in a political community.*
>
> *(DAVISON 2000:263)*

Another reason for the value of history is that it can help us to understand how things have come to be, why some things change and others do not, or are difficult to change (Davison 2000). Applied to nursing and healthcare, history can illuminate the background to issues in the contemporary field, many of which are not new (Connolly 2004, Fairman & Lynaugh 1998, Lewensen 2004, Nelson 1997, 2004). In the case of Australian nursing, examples of perennial issues include concerns about shortages of nurses and midwives, educating nurses, and regulating nursing practice (Grehan 2009a). Further, Australian historian Sioban Nelson argues that history can help us to understand the extent of the impact of nursing on healthcare and society (Nelson 2000).

History can offer valuable insights into what the future might bring, although clearly it is impossible to be certain about the future. But if we understand what has influenced the development of nursing and the longstanding issues it has faced, it may be possible to devise novel responses to these longstanding issues. How, then, can nurses learn about the history of nursing?

TRADITIONAL VIEWS OF HISTORY

In the early twentieth century, nurse luminaries in the United States of America

(Nutting & Dock 1907) and Britain (Tooley 1906) recorded the triumphs of the nursing profession. Histories of Australian nursing (Walsh 1955, Webster 1942) and New Zealand nursing (Maclean 1932) reiterated the celebratory achievements of nursing. The premise of these accounts was simple: the care of the sick and of childbearing women was unskilled work of low status until so-called Nightingale nurses worldwide transformed bedside attendance from an age of darkness into one of light, from ignorance into science, from an occupation into a profession. This attitude change came about largely because popular culture presented audiences with accounts of prominent nurses, such as Florence Nightingale, whose role in the Crimean War (1853–1856) was featured in numerous films. Likewise, the life of Elizabeth Kenny and her pioneering of physical therapies for poliomyelitis were featured in a 1946 movie, *Sister Kenny.*

Histories along these lines are referred to as 'received' history. Usually devoid of context and analysis, they offer simplistic explanations of complex episodes and events. In the case of nursing, they ignore, among other things, the contribution of everyday nurses, and aspects of history that do not 'fit' a narrative of the progress of nursing. In recent decades, more enlightened views of the history of nursing have emerged in the form of critical history.

AN ENLIGHTENED VIEW OF THE HISTORY OF NURSING

When writing about the history of nursing in Australia (Godden 2006, Nelson 2000, Strachan 2001), New Zealand (Sargison 2001, Wood 1992, 2008), and elsewhere (Baly 1987, Connolly 2004, D'Antonio 1999, Helmstadter & Godden 2011, MacPherson 1996, Nelson & Rafferty 2010, Rafferty et al 1997), scholars have used the tools of critical history to reappraise conventional narratives. Critical history rejects long-held assumptions, such as the idea that history is about progress, or that complex events can be explained simply. A critical historical approach considers nursing as a fundamental part of the society that it serves, within political and social contexts (Connolly 2004).

Critical history, in providing a measured and effective analysis, can address omissions from received histories, such as the contributions of Aboriginal and Torres Strait Islander nurses. Indigenous women like Sadie Corner (pictured in Fig. 2.1) and Lowitja (Lois) O'Donohue had to overcome considerable odds to train as nurses and work in Australia's white healthcare system. Examining the role of Indigenous nurses in Australia and New Zealand entails consideration of politics, race, social attitudes and geography. The contribution of Indigenous nurses is just one of many fascinating and instructive episodes in Australian and New Zealand nursing history worthy of critical inquiry.

FIGURE 2.1 Sadie Corner *Source: Salvation Army Australia, Southern Territory Archives and Museum, Melbourne and Sadie Canning, née Corner.*

The roots of modern nursing

As Nelson (2000) puts it, the act of nursing is as old as the human race. With this longevity, it is difficult to pinpoint the so-called 'roots' of nursing. An alternative is to begin with the present. If we accept the premise that nursing in the twenty-first century is 'modern', from that standpoint it is possible to identify the antecedents that have

evolved to produce nursing in its modern form.

In the twenty-first century, a large proportion of healthcare is provided in what historians call the 'modern' hospital. The concept of the 'modern' hospital emerged in the Western world in the late nineteenth century, a time when medicine was developing a sophisticated understanding of disease and illness, applying germ theory and experimenting with novel treatments such as vaccinations and surgery (Rosenberg 1987). Received medical history held that the modern hospital was an innovation because it replaced disorder with order and hierarchical systems of caregiving. The emergence of modern nursing, with its own hierarchical structures, was lauded as a parallel element in this medical innovation (Nelson 2000). Yet the hospital, as a place for delivering systematised care, was not a 'new' concept. Rather, the modern hospital and modern nursing constituted new ways of doing 'old' things, in which old structures and standards were replicated but were evangelised as 'modern' and innovative. The forebears of modern nursing, similarly, can be found in these older ways of care provision (Nelson 2000).

PRE-MODERN NURSING

The historical antecedents of modern nursing lie with the care of the sick poor as strangers, provided by religious orders as 'an integral part of Christian practice' (Nelson 2000:3). In the early Christian era and beyond, religious orders emulated the work of Jesus Christ in tending to his flock by providing care in hospices (early forms of hospitals), feeding the poor, tending the infirm, and applying palliative treatments. One group of nurses who has sustained this philosophy of care for centuries is the Catholic religious order, the Sisters of Charity of St Vincent de Paul (Nelson 2000), mentioned later in this chapter.

The care of the sick poor as a charitable endeavour was practised, too, by Protestant organisations in the nineteenth century. In England, for example, female followers of Christianity, among them Elizabeth Fry, Jane Shaw Stewart, Agnes Jones and Sister Dora [Pattison], formed nursing 'sisterhoods' through which nursing care was provided to the poor (Summers 1989). Research by Carol Helmstadter and Judith Godden (2011) has established that, during the first half of the nineteenth century, some hospitals in London contracted out their nursing to sisterhoods. These charitable conventions were emulated in Australia where philanthropically minded Christian people organised care provision to the poor (Grehan 2009a). The difference was that the latter organisations were underpinned by a strong moral compass that determined need on the basis of an individual's deservedness. This judgemental approach had a foundational influence on the development of care provision in Australia and New Zealand.

Healthcare in early Australia and New Zealand

As the British Empire expanded in the eighteenth century, its conventions of caregiving were replicated in the newly claimed colonies of Australia (Grehan 2004) and New Zealand (Sargison 2001). Records, primarily coronial inquests, that describe nursing and midwifery care in the early years of the colonies, reveal that it was often primitive, performed without modern-day technologies of sanitation, in circumstances where

water was obtained from a nearby stream or a stagnant pond, where 'watching' the patient at night was done by candlelight and where help in the form of a doctor or educated nurse was several days' travel away by horse or on foot (Grehan 2009b).

ESTABLISHING INSTITUTIONS

At the convict settlements of Sydney and Hobart Town, Australia's colonial governments established general hospitals to accommodate those on the pay roll of the civil establishment (soldiers, for example). Midwives were appointed by the New South Wales (NSW) government to specific geographic locations and female factories, while lunatics were housed in government asylums (Grehan 2009a). In Australia's other colonies, and in New Zealand (Sargison 2001), institutions emerged from the 1840s, developed by the charity sector for the indigent. Known as 'voluntary' or 'charity' hospitals, the work of these institutions was funded by subscription; in return for their financial support, subscribers were able to recommend individuals for hospital treatment (McCalman 1998). As colonists expanded the white frontier, local communities constructed hospitals, following industrial catastrophes such as mining accidents (Collins 1999).

Hospitals, however, were thought to harbour miasmas, the noxious vapours believed to emanate from filthy conditions, suppurating wounds, ill-ventilated rooms, cesspits and cemeteries (Grehan 2009a). The theory of miasmatism dictated that vapours resulted from certain disease states, such as smallpox, tuberculosis and forms of cancer, so people with these conditions were excluded from admission to hospitals. Pregnant women, likewise, were not permitted admission to general hospitals for fear that miasmas posed risks to the healthy state of pregnancy (Grehan 2009a). For this reason, institutions for women (maternity hospitals, called lying-in institutions) were established quite separately from general hospitals, mirroring practice in England, Scotland and Ireland (McCalman 1998).

Institutional nurses

Hospitals and institutions in the colonial world were hierarchical places. What a nurse was expected to do when working depended on the type of establishment where she was employed, and on what basis she was employed—that is, as a head nurse, assistant nurse or pupil nurse. Some hospitals were operated by a married couple who attended to the patients, cooked their food and did the laundry (Collins & Kippen 2003). Asylums (Monk 2008) and other establishments, particularly in rural areas (Collins & Kippen 2003), employed men and women as attendants for male and female patients respectively. Mid-nineteenth-century nursing was extremely hard work for little reward, a mixture of bedside attendance and household tasks.

An adherence to miasmatic theory translated into concerns about the sick person's environment as potentially harbouring disease, so the practice of 'sanitary' science was applied throughout hospitals and institutions to minimise miasmas. This meant that nurses were expected to maintain the purest environment possible, via an extensive regimen of cleaning and ventilation practices (Nelson 2000). Nursing included scrubbing floors, brushing carpets, dusting, polishing brassware and furniture, washing

the patients, providing nourishments for those who could not do it for themselves, making and applying poultices and similar remedies. Some hospitals required the nurses to sleep at the end of wards so that they could attend the patients when necessary (Grehan 2009a). With hospitals unsewered until the late nineteenth century, it was the nurses' job to dispose of bodily wastes such as blood, faeces, urine and sputum, emptying the excreta stored in buckets at the end of wards into outdoor cesspits (Templeton 1969). Nurses had to clean and fumigate straw mattresses, known as palliasses, in special airing rooms, and carry soiled linen to the laundry for washing (McCalman 1998).

Attracting new recruits was always difficult, because hospital nursing did not enjoy a lofty position in society in the mid-nineteenth century. Newspapers reported nurses being drunk on duty, being cruel to patients or being ignorant (Grehan 2004). Institutions such as The Women's Hospital in Melbourne attempted to weed out potential troublemakers, and those unlikely to succeed, at the start. Pupil nurse applicants had to provide a testimonial from a minister of religion or medical practitioner, vouching for the nurse's character. And as most institutions did, the management of The Women's Hospital vetted the patients to check that each was respectable and deserving of the hospital's charity (McCalman 1998). Hospitals, it has to be said, accommodated only a small proportion of the population. For most people, an individual's home was where care was delivered (Grehan 2009a).

CARE PROVIDED IN THE COMMUNITY

The sick and childbearing women in colonial Australia had a range of people to choose from when engaging a bedside attendant, among them: doctors, nurses, midwives, herbalists, oculists, druggists and dentists (Grehan 2009a). Similarly in New Zealand, a range of people practised (Sargison 2001). Who the patient chose depended on who was available, what the purchaser expected of his or her care, and what the patient was willing to pay. In the cities and in rural areas, local women attended births and cases of sickness as a neighbourly gesture (Grehan 2009a). Some women combined tending to the sick, preparing the dead for burial, and acting as midwife, with running the local postal service (Forth et al 1998).

Employment for women in the colonial world was hard to find, making nursing and midwifery practice easy to adopt as paid work, especially when family circumstances changed. Some women attending births in Australia had only their own experience of childbearing and rearing; others had none. Some learnt their craft by apprenticeship, while others attended public lectures given by doctors. A proportion held formal qualifications from theoretical and practical education schemes available in Britain or Europe (Grehan 2009a). But without any regulation of practitioners, their practice, or their prices, selecting an attendant at birth or at times of sickness was like a lottery as there was no guarantee of an individual's skills. Women who attended others for payment were referred to as 'handywomen', a derogatory term that implied that they had no education or training for their work, and undertook it simply for the money (Grehan 2004).

A study by historian Glenda Strachan (2001) of all births registered in an isolated

rural district of the Colony of NSW, during the years 1856 to 1896, confirms this range of maternity attendance by women. In South Australia, nursing historian Joan Durdin (1991) cites the example of Mrs Elizabeth Knight, a well-respected midwife in the Mount Gambier region who began her work at the age of 70 after the death of her husband. In New Zealand, Sargison (2001) reports numerous women and men who fulfilled the role of attendant on the sick and on childbearing women. Critics of this unregulated and haphazard arrangement of care provision were vocal, and perceptions prevailed that the majority of colonial nurses were unsuited to the important duty of caring for the sick and for childbearing women.

WORLDWIDE CALLS TO REFORM NURSING

Disapproval of domiciliary and institutional nurses was fuelled in part by the writings of author and social commentator Charles Dickens whose serialised novel *The Life and Adventures of Martin Chuzzlewit* (1843) opened a window on the realm of private nursing. *Martin Chuzzlewit* introduced two fictitious but infamous London characters, Sarah Gamp and her friend Betsy Prig. Mrs Gamp, styling herself as a nurse and midwife, was available for all work: births, tending to the sick and laying out of the dead. Prig was a hospital nurse by day and moonlighted as a 'private' nurse in people's homes at night. Dickens' narrative, combined with graphic pen and ink sketches, depicted the two 'nurses' as ignorant, unrefined and untrustworthy reprobates. The term 'Gamp' came to symbolise all that was perceived to be wrong with female nurses and nursing throughout the English-speaking world (Grehan 2004).

A human antithesis to Mrs Gamp appeared within 15 years of the premiere of the fictional nurse, in the form of Miss Florence Nightingale. A charitable organisation in England, the 'Nightingale Fund for Nursing', was established following a public subscription campaign to recognise Nightingale's work in the Crimean War. Miss Nightingale rejected any personal testimonial, instead recommending that the Fund establish an institution for the training of nurses and hospital attendants. The Fund's enduring message was that nursing needed role models, educated 'ladies' of good character who could demonstrate to less educated nurses how to behave (Baly 1987). Donations to the Fund were forthcoming from Australia and newspapers soon reported that nurses would be trained 'properly' as a result (*Argus,* 10 July 1856). In New Zealand, too, the Fund was supported as a patriotic venture (*Southern Cross,* 18 November 1856).

The Nightingale Fund established two training schools in London. At St Thomas' Hospital nurses were to be trained for general work in public hospitals and infirmaries. And at King's College Hospital women undertook training in midwifery nursing with sponsorship from local communities who wanted nurses for the poor, but the King's College school closed after only five years (Baly 1987). Nightingale's name was attached to the school at St Thomas', but in practical terms she had little to do with its operation (Godden 2006). Nightingale's greater influence came through her multiple publications on all things associated with nursing: nurses, midwives, training, caregiving, disease, hospital design and sanitary science, all of which were embraced in the colonial world (Grehan 2009a).

The context within which Nightingale's ideas gained traction is relevant. Miasmatic theory dictated that ill-health was a problem of dirt, literally and metaphorically, and sanitary science was widely accepted as the appropriate response to sickness and disease. As Bashford (1998) puts it, female unmarried nurses were positioned as the ideal agents to fulfil the objectives of sanitary science, sweeping a new broom through institutions and thereby elevating nursing to a vocational calling.

Other forces hastened reforms in nursing and potentiated the feminisation of the workforce. With the emergence of the modern hospital came new treatments and surgical operations that required a team of staff to guarantee success (Helmstadter & Godden 2011, Rosenberg 1987). The nurses providing pre-operative and post-operative care needed to be literate, cooperative and diligent; they needed to be able to observe changes in the patient's state, apply new technologies such as the thermometer, use a watch to count pulsations (Grehan 2004) and deliver complex regimens of nutrition and pharmacological agents via poultices and enemas. In the last quarter of the nineteenth century, hospitals in Australia (Grehan 2009a) and New Zealand (Sargison 2001) introduced their own training schemes for pupil nurses.

Institutional training schemes

Nurse 'training' in hospitals, it has to be said, was far less sophisticated than the term suggests. It involved on-the-job learning, combined with lectures by medical practitioners and sometimes senior nurses, which pupils attended only if they could be freed from their ward work (Mitchell 1977). Up to the turn of the twentieth century at least, nurse training was organised around an institution's associated medical specialty. The result was an idiosyncratic training in nursing. For instance, an eye and ear hospital's training scheme produced eye and ear nurses; children's hospitals produced children's nurses; lying-in hospitals produced nurses for maternity and gynaecological care and so on. Nurse training in Australia was so specific to each hospital's needs that the nurse's skills were not always transferable to another hospital environment (Trembath & Hellier 1987).

Some hospitals even hired out pupil nurses to private patients in the home. A pupil nurse could spend a substantial portion of her training time away from the hospital, without any supervision and learning very little as a consequence (Templeton 1969). The variability in training schemes meant that the concept of a 'trained' nurse was fluid. Coupled with the plurality of attendants working in the community, it is little wonder that ideas of compulsory, uniform training, proof of claimed qualifications, and superior senior nurses of impeccable character who could raise standards in nursing, were enthusiastically welcomed in the colonies.

In 1868, a cohort of so-called Nightingale nurses arrived in Australia, superintended by Miss Lucy Osburn (pictured in Fig. 2.2), notionally to improve conditions at the Sydney Hospital. The received history of Australian nursing celebrates this Nightingale-associated milestone as breaking new ground, but Judith Godden's (2006) research on the Sydney Hospital shows that it was not ill-managed at all under its then matron, Bathsheba Ghost.

FIGURE 2.2 Lucy Osburn *Source: South Eastern Sydney and Illawara Area Health Service, NSW Government.*

Other Nightingale-associated events have enjoyed prominence in Australian nursing history. In the southern colony of Tasmania, three 'Nightingale' nurses were welcomed in 1885, reportedly to institute necessary urgent reforms at Hobart's General Hospital. Yet recent research shows that the success of the three has been substantially overstated (Grehan 2015). Two of the three later worked in colonial Victoria where they are recorded again as having instituted urgent and necessary reforms (Grehan 2004). In New Zealand, received history similarly records accounts of neglect and wretchedness in hospitals that subsequently were transformed under the watch of reputable nurses with Nightingale connections. French (2001) notes Mary Lyons, Mrs Bernard Moore and Annie Crisp among these women, the latter credited with overhauling nursing at the Auckland Hospital and establishing its nurse training school. Crisp, awarded a Royal Red Cross in 1883, was a military nurse feted for her work in Africa (Masters 1993).

As the story goes, under the steady eye of these superior nurses, hospitals around Australia (Grehan 2004) and New Zealand (Hill 1982) adopted the so-called Nightingale scheme of nurse training, with its two categories of pupil. 'Lady' probationers paid for their training, were exempt from menial work, and were expected to supervise their subordinates. 'Regular' probationers did not pay for pupillage but trained for longer; they did household work and scrubbing, and were expected to model the example set by their superiors. Received history tells us that the Nightingale model transformed the healthcare landscape (Grehan 2009a), that it was universally embraced within all hospitals without a shred of resistance. Was this really what happened?

In fact, research by Godden (2006) and Grehan (2009a, 2015) shows that the evolution of nurse training in Australian institutions was far more complex. Further, Monk's (2015) work on bedside employees in colonial Victoria's government asylums shows that male warders and attendants were firmly opposed to any education as part of their employment conditions. Female asylum nurses in the same institutions were more amenable to attending lectures on nursing that were offered in the 1890s. There is no doubt that some hospitals modernised training, but the process of doing so was difficult and expensive so change was achieved only incrementally. There was no miraculous shift from old to new models of training. When changes were introduced no one individual, or group of individuals, was responsible for those developments, despite what received history would have us believe. Finally, reforms that were made in nursing and hospitals did not occur in isolation. As Nelson (2000) argues, these developments were just one element in a wave of lasting social change that swept throughout the English-speaking world in the late nineteenth century.

From the haphazard world of nineteenth-century nursing and midwifery, our discussion now moves to the twentieth century, to consider some of the factors that have shaped nursing and midwifery practice as we know them today.

Some historical influences on nursing

Nursing, like other professions and occupations, exists as part of the society it aims to

serve. While nursing has been shaped by the profession itself to an extent, it has also been subject to external factors well beyond its control. Some of the major influences on nursing are obvious. Perhaps the most consistent is the constantly evolving technologies of care, from the thermometer to all sorts of instruments that deliver measurements of clinical status, practices such as fluid replacement, asepsis, infection control and myriad others. All of these developments have changed the way nursing is performed at the bedside, and nursing today continues to respond to novel technologies of care.

New ideas about the concepts of health, wellbeing and illness have impacted on nursing education and practice too (Grehan 2009a). Less obvious influences are the political, economic and social climate in which nursing is practised. Historically, one critical external influence on nursing in Australia has been the three tiers of government that hold differing responsibilities for aspects of healthcare provision. Financial conditions within which governments operate have impacted on hospital funding, with inevitable flow-on effects for how nurses and nursing is funded within hospital budgets. Changes of government mean that the policy platform can change rapidly with effects on the clinical arena (Grehan 2008).

With a critical examination of the history of nursing, it is possible to reflect on the way that external factors and trends, momentous and less momentous events, have shaped nursing as we know it today. Earlier in this chapter we discussed mounting pressure in the last decade of the nineteenth century to raise standards in nursing and midwifery attendance (Grehan 2009a). How governments in New Zealand and Australia responded to these calls stemmed from the structure of those governments. The entirety of New Zealand was one colony with a small population, and the government instituted statutory regulation for nursing seamlessly (Maclean 1932). By contrast, when Australia's six colonies became states at Federation in 1901, each state apart from Tasmania continued to resist regulating nursing because of a belief that government should not interfere with individual health, except for specific groups. Thus, in Australia, disagreement persisted on how to run hospitals, how to teach nurses, what to teach nurses and even what constituted a nurse. Arguments prevailed over the length of training, what it should consist of, and whether training was beneficial at all (Grehan 2009a). In the absence of regulation by government, sectors in the Australian nursing fraternity opted for voluntary professional self-regulation.

VOLUNTARY REGULATION

Australian efforts to introduce voluntary professional regulation for nurses and midwives mirrored those in Britain where a British Nurses' Association was established in late 1887 (Grehan 2009a). Voluntary professional regulation was designed to do what legislation might have done: differentiate trained nurses from untrained people by setting standards in education and training, and by maintaining publicly accessible registers so that the public could choose trained nurses who had signed up.

A Victoria Trained Nurses' Association formed in 1886 as a professional organisation of private nurses in the city of Melbourne, but it endured for only two years. In 1891, Tasmanian nurses agitated to form a professional association in that colony, but without a critical mass, turned to Victoria where a Nurses' Association of Australasia was

founded in Melbourne in 1892. It failed to flourish, but momentum was gathering and two subsequent associations endured (Grehan 2004). The Australasian Trained Nurses' Association (ATNA) based in NSW was established in 1899. The Victorian Trained Nurses' Association was established in 1901, and in 1904 became the Royal Victorian Trained Nurses' Association (RVTNA) after being awarded Royal Charter (Trembath & Hellier 1987).

These professional organisations have been judged as having marginal impact (Trembath & Hellier 1987). For nurses and midwives in many parts of Australia, especially those in private practice, voluntary regulation made little difference because they did not need to be registered to gain employment. Even so, the long-term influence of these organisations deserves some credit. Both associations forced larger hospitals to institute uniform curricula, examinations and certification, which gradually came to be accepted. It helped that the ATNA's and RVTNA's membership base included influential doctors whose support for regulation was critical in securing the cooperation of the hospital sector. When legislation was eventually introduced for nursing and midwifery, at different times in different states and territories of Australia, the ATNA's and the RVTNA's system informed aspects of registration (Grehan 2009a).

Voluntary regulation preceded statutory regulation in all states and territories of Australia, but in New Zealand the reverse occurred. There, a voluntary professional association for 'private' nurses, the New Zealand Trained Nurses' Association, formed in 1909 as a response to developments in the international nursing arena (Sargison 2001). The International Council of Nurses (ICN), founded in 1899, was providing a voice for nurses worldwide but member countries needed to have a national nurses' association that was governed by nurses (Grehan 2009a). Because the New Zealand Trained Nurses' Association was a national organisation, governed by nurses and not doctors, that country became a member of the ICN much earlier than Australia did. It took until 2011 for Australia's two colleges of nursing, the Royal College of Nursing Australia and The College of Nursing based in NSW, to overcome long-held differences and unite as a national college, the Australian College of Nursing (Grehan 2012).

STATUTORY REGULATION

As we have noted, New Zealand's pathway to government regulation of nursing and midwifery was uncomplicated. New Zealand appointed a Scots-born, English-trained nurse, Mrs Grace Neill, to assist in developing its legislative framework. Regulation for all nurses applied in New Zealand from 1901, and a *Midwives Registration Act* was passed in 1904 (French 2001). When the six colonies in Australia became states, the 1901 Australian Constitution protected their capacity to regulate aspects of commerce, trade and legal matters (Macintyre 1986). This included the regulation of occupations and professions. Consequently, statutes and subordinate regulations pertaining to nursing and midwifery varied considerably across Australia, with reciprocity of registration between the states a major obstacle for nurses who sought employment opportunities across state borders. Tasmania introduced the first statutory regulation in Australia for nurses practising midwifery, in 1901. By the mid-1920s, legislation governing midwifery and nursing practice had been passed in the other states (Grehan 2009a).

Externally to the profession, the development of trade agreements and the globalisation of workforces have forced change in the way that nurses and midwives are registered as healthcare practitioners. In 1992, the Australian and New Zealand national governments signed a *Mutual Recognition Agreement,* extending it in 1997 to include the Australian state governments under the *Trans-Tasman Mutual Recognition Act 1997* (Cth) and in New Zealand as the *Trans-Tasman Mutual Recognition Act 1997.* Designed to 'promote economic integration and increased trade', these agreements have enabled the mutual recognition of most occupational qualifications in New Zealand and Australia, including nurses and midwives. Within Australia, a national registration system for all nurses and midwives was introduced in July 2010 (Australian Nursing and Midwifery Board 2010), making qualifications within the nation portable.

Thus, to develop an accurate perspective of the history of nursing, it is essential to look beyond the profession itself, to the political landscape, to societal shifts in understanding of health and illness, and to issues of gender. Tumultuous events, also, have had a lasting influence on nursing, stimulating the profession's aspirations. Some of these are considered next.

Milestones in Australian and New Zealand nursing

Even in the relatively short history of nursing in New Zealand and Australia, significant events and notable occasions have had lasting effects on the profession. Here we concentrate on two particular milestones in the history of nursing. The first is the role of war; the second is the development of nursing education and the eventual transfer to the tertiary setting. It is their context and their sequelae that are of interest in historical terms.

WAR

A consequence of being part of the British Empire is that military conflicts that involved Britain, involved Australia and New Zealand. Military conflict has been a significant and consistent theme in nursing history, beginning with Nightingale's well-publicised role in Crimea and, following that, women's contributions during the American Civil War (1861–1865), which attracted the admiration of the public worldwide. Nelson writes that 'the successes of the war nurses stimulated a shift in public perceptions of the role of the nurse' because, in the organised arena of tending the war wounded, 'nursing came to be seen as a useful profession' and a rather more lofty exercise than simply nursing the poor (Nelson 2000:148).

The Anglo-Boer War, World Wars I and II

By the turn of the twentieth century, nurses believed their profession was useful indeed. During the Second Anglo-Boer War (1899–1902), nurses from the Australian colonies and from New Zealand volunteered (Speirs 2010). In late 1899 a group of NSW nurses formed the first Army Nursing Service Reserve in Australia. Fourteen nurses were despatched to South Africa and paid for by the NSW government, the only colony to do so. Others joined the Imperial service, with support from public subscription

campaigns, while yet others served as private citizens. In World War I (1914–1918), New Zealand-trained nurses served in stationary hospitals, trains, hospital ships and other locations (Dahl 2009). Of the estimated 550 New Zealand nurses who served, 10 died when the *Marquette,* a British transport ship carrying medical corps personnel, was torpedoed in the Aegean Sea (Maclean 1923). More than 2500 nurses served with the Australian Army Nursing Service (AANS) in the Middle East, in the south of Europe, France, England and India on land and sea (Harris 2010).

Australian nurses volunteered during World War II (1939–1945), serving in North Africa, the Middle East, the south of Europe, and across the Pacific, as members of the three areas of the Australian military forces: the AANS, the Royal Australian Air Force Nursing Service and the Royal Australian Naval Nursing Service (Harris 2007). In 1943 nurses in the Australian forces were awarded military rankings, formally placing women in charge of men at a time when no comparable positions were open to women in civilian life (Milligan & Foley 1993). Similarly, New Zealand recognised serving nurses as officers at that time (Clendon 1997).

Two particular events in World War II involving Australian nurses encapsulated the inhumanity of war and drew attention to the roles and sacrifices of ordinary women who risked their lives in their work as military nurses.

The sinking of the *Vyner Brooke* and the Bangka Island massacre

In February 1942, when the city of Singapore was invaded by Japanese forces, members of the AANS were serving in a military general hospital there. A group of 65 nurses was forced to evacuate with civilians, leaving Singapore harbour on a small coastal steamer, the *Vyner Brooke* (Shaw 2010). The *Vyner Brooke,* with more than 200 passengers aboard, made its way through the Malacca Straits, where the vessel was one of several attacked by Japanese bombers from the air.

Some survivors of the *Vyner Brooke*'s bombardment and sinking managed to swim ashore to Radji Beach on the Indonesian Island of Bangka, landing in two groups on different parts of the coast. One group, including 31 nurses, was taken as prisoners of war; a second party of service personnel and civilians was discovered by Japanese soldiers two days later. The men were separated from the women and marched away. The soldiers ordered the nurses to march into the sea where they were shot. Vivian Bullwinkel, then aged 26, was the only survivor of this war crime. After hiding for 12 days in the jungle with a severely wounded British soldier, Bullwinkel surrendered to the Japanese army, and was reunited with the other party of nurses. Until the end of the war, this group of women remained secret prisoners of war. News of the Bangka Island massacre did not reach Australia until well after hostilities had ceased in 1945 (Jeffrey 1954).

The sinking of the Australian Hospital Ship *Centaur*

A second incident occurred in May 1943, just off the Queensland coast, north east of Brisbane. The 2/3 Australian Hospital Ship, *Centaur,* was on its second journey from Sydney to Papua New Guinea to collect injured servicemen. *Centaur* carried 332 non-combatant personnel: doctors, field ambulance officers, ship's crew and 12 AANS

sisters (Milligan & Foley 1993). At 4.10 a.m., *Centaur* was torpedoed by a Japanese submarine, without warning. Of those on board, 268 were killed and only one of 12 nurses survived. During the 36 hours that passed until the *Centaur*'s survivors were rescued, this remarkable nurse, Ellen Savage (pictured in Fig. 2.3), took charge of rationing food and attended to some of the 64 injured survivors, for which she was awarded the George Medal, Australia's civilian equivalent to the Victoria Cross. Her nursing work took place on a raft in the Pacific Ocean and despite her own severe injuries: a fractured palate, nose and ribs, as well as perforated ear drums, burns and severe bruising (Milligan & Foley 1993).

FIGURE 2.3 Ellen Savage GM *Source: AWM 61952.*

The sinking of the *Centaur* was judged to be a war crime because hospital ships were protected according to the Geneva and Hague Conventions (Milligan & Foley 1993).

The loss of the 11 nurses was used in a propaganda campaign by the Australian government that exhorted Australians to avenge the nurses' deaths by actively supporting the war effort. Subsequently, the Australian public gave generously to various war nurses' memorials, including the Centaur Memorial Fund for Nurses in Queensland and the War Nurses Memorial Centre in Melbourne (Williams 1991).

On the home front

The duration of World Wars I and II had substantial impacts on nursing and midwifery, certainly in Australia. In World War I, deficits were created in every area of nursing across the nation when nurses joined up (Harris 2007). Some hospitals attempted to overcome the shortage by extending nursing training from three to four years, but this had an unintended effect of discouraging young women from applying for training places. Another Australian response was to introduce the 'war emergency nurse' in 1915 when there were no fully trained nurses to do the work. After the war there were disputes about whether these nurses should be allowed to continue as nurses (Grehan 2009a). In the five years before World War I, a Bush Nursing scheme was formulated in Australia to provide healthcare, particularly maternity care, to Australians in rural and remote areas. Nurses who wanted to work as Bush Nurses had to hold qualifications in midwifery and general nursing. This strict policy had to be relaxed when the scheme could not attract nurses with a general nursing certificate (Grehan 2009a). In New Zealand, during the early twentieth century, a similar scheme to supply rural and remote areas with trained nurses was known as 'back-blocks' nursing (Wood 2008).

In World War II, out of an estimated 13,000 nurses working in Australia, around 4000 volunteered. Shortages of trained nurses became so dire that the Australian government recognised the importance of nursing to national stability (Nelson & Rabach 2002) and designated it a protected industry. From 1942 until 1945, nursing was under the control of the Manpower Directorate, a federal authority. Any nurse who wished to either work or train interstate required the permission of the Directorate to leave the state in which she lived. But it was possible to circumvent the restrictions. Some nurses found someone willing to exchange places interstate, and would then contact the Manpower Directorate for permission (Grehan 2009a).

Adjustment to civilian life after the war must have been difficult for service nurses, but particularly so for those who had occupied positions of authority in the military. Colonel Annie Sage was Matron-in-Chief of the AANS from 1943 until 1947. Back in civilian roles, Sage was unable to reach the heights of leadership that were tacit in her military position. Sage's aspirations to lift Australian nursing out of the realm of women's work into an even more professional sphere were dashed at The Women's Hospital in Melbourne where her authority was challenged vigorously by civilian doctors (Nelson & Rabach 2002).

One of the significant aspects of war service was that with so many Australian and New Zealand nurses in the military, they mixed with counterparts educated under different systems in other countries. In this way, nurses' eyes were opened to alternative ways of learning, teaching and practising their profession. Most understood that developing and expanding education was critical to the growth of nursing, yet

opportunities for nurses to undertake postgraduate education were extremely limited. In the post-World War II period, nurses in Australia successfully harnessed the support of the public to establish 'centres' for the profession. These centres were living memorials, acknowledging the deaths of nurses on active service through the development of professional activities, particularly postgraduate education. Our discussion now turns to this aspect of the history of nursing.

DEVELOPING EDUCATION

The apprenticeship mode of training nurses on the job in hospitals was the mainstay of institutional nursing education throughout the nineteenth and twentieth centuries. Under that model, service provision came first, with a smaller weighting on education (Trembath & Hellier 1987). For nurses who wanted more education than the triple certificates of general nursing, midwifery and infant welfare nursing, courses were available at American universities, in England at the Royal College of Nursing (Smith 1999) and in New Zealand from 1928 at the Wellington Hospital in conjunction with Victoria University (Sargison 2001).

A national college of nursing in Australia was the goal of both the ATNA based in NSW and RVTNA in Victoria, but neither wished to be a state branch of the other. In Victoria, the RVTNA metamorphosed into the Royal Victorian College of Nursing (RVCN), which offered postgraduate courses in teaching, administration and industrial (now occupational health) nursing from the 1930s. A notionally national organisation, the College of Nursing Australia, based in Victoria, was established formally in early 1949. In May of the same year, NSW established a separate college, offering postgraduate education programs with support from professional groups in that state (Smith 1999).

Despite their differences, both entities shared the philosophy that beginning practitioners should receive a broad-based education in the tertiary sector. A foundational degree in general nursing was to produce nurses ready to practise in a range of clinical areas. Specialisation in nursing was to follow through postgraduate studies. By the 1970s, momentum had gathered to realise this goal (Lusk et al 2001). In 1977, after continued lobbying from the profession, the NSW state government transferred nursing education from the health portfolio to education, a move that enabled the state's Colleges of Advanced Education to assume responsibility for pre-registration nurse education. Other states and territories followed. In 1984, under an Australian federal government plan, nursing as a pathway in tertiary education became a reality (McCoppin & Gardner 1994). Midwifery education was transferred to the tertiary sector by the early 1990s. Hospital-based pre-registration psychiatric nursing was phased out in the mid-1980s so that psychiatric nursing was available only as a postgraduate specialty following a degree in general nursing. This change was confluent with deinstitutionalisation, whereby large psychiatric institutions closed, and care was transferred to community-based services. Collectively, these shifts in Australia ended 140 years of nurses learning their work by apprenticeship. Similarly, in New Zealand, apprenticeship in hospitals was replaced gradually by diploma-based education in technical institutes, beginning in 1973 under pilot programs, and in the

mid-1990s an undergraduate degree program was formally adopted as the only pre-registration pathway (Lusk et al 2001).

Streams of specialisation

Much of our discussion has focused on the 'general' nature of nursing, but an important element in the history of nursing has been the specialisms that have developed within clinical practice. At least some specialisms emerged alongside the institutions that catered for those cases medically, such as eye and ear hospitals, which produced eye and ear nurses, orthopaedic hospitals and so on. Writing of New Zealand, Prebble and Bryder (2008) point out that psychiatric nursing, formerly called mental nursing, had its foundations in asylums, which were geographically and philosophically distant from other hospitals' nurse training schemes.

Some specialisms emerged in tandem with rapid developments in medicine but not always because of medicine itself. One example, associated with a specific body of nursing knowledge, is the development of the intensive care nursing unit in the 1960s (Fairman & Lynaugh 1998). Maxine Dahl (2009), a historian of Australian military nursing, argues that Royal Australian Air Force air evacuation nurses were responsible for establishing the specialty of flight nursing and retrieval, during military service in World War II and the Korean War (1950–1953).

Numerous specialisms within nursing sometimes reflect a combination of the location of care, the practice undertaken and the population receiving care; for example, community health, neonatal intensive care, coronary care and occupational health, school nursing, to name a few. Other specialisms reflect the practices undertaken, such as stomal therapy, diabetes care, infection control, women's health, adolescent health, cancer nursing, tissue transplant nursing, paediatrics, health promotion and palliative care, all specialty nursing practice areas that have emerged since the 1970s. The history of their individual development as specialisations in nursing and healthcare will make for fascinating historical inquiry in the future. Another area of historical interest is the relationship between history and professional identity, to which our discussion now turns.

History and identity

Earlier in this chapter, we noted that history can tell us about our identity as individuals and as members of a recognised profession. We have seen that the identity of nursing in received histories is linked to a sense of the profession as a 'modern' entity with many branches. The relationship between identity and history is illustrated well by developments in the field of midwifery. For the greater part of the twentieth century in Australia, midwifery was considered midwifery 'nursing'; that is, a specialist branch of the practice of nursing. Since the 1980s, in New Zealand and Australia, the status of midwifery as a branch of nursing has been disputed, as part of a worldwide movement aimed at professionalising midwifery. This movement seeks to have midwifery in Australia recognised as a profession, separate and distinct from nursing, as it is in the Netherlands, New Zealand and other parts of the Western world (Australian College of

Midwives Incorporated Victorian Branch 1999). New Zealand's government placed midwifery and nursing under separate legislation in 1990 (Grehan 2009a). After the subsequent development of the Bachelor of Midwifery (BM), a freestanding educational stream leading to registration as a midwife, this undergraduate course is the only pathway to becoming a midwife in New Zealand. Emulating that direction, several Australian universities introduced the Bachelor of Midwifery (BM) in 2001, although midwifery education in Australia can still be pursued at postgraduate diploma level. This development raises the relationship between a profession, its identity and its history.

THE IDENTITY OF MIDWIFERY, NOT 'NURSING'

The main distinction between nursing and midwifery for proponents of the BM is that midwifery involves care in a natural healthy episode in the female life cycle; nursing, in contrast, is said to concern the care of the sick (Fahy 1998). Proponents of this distinction argue that the history of midwifery, its lineage and its identity, is vastly different from that of nursing (Grehan 2009a). 'Identity' histories, sometimes categorised as 'revisionist' histories, have been popular since the 1960s when second-wave feminism and the movement in social change critiqued existing historical narratives as a march of progress (Davison 2000). Revisionist history aimed to give 'voice' to groups whose contributions had been ignored in received interpretations of history, such as women, African Americans, ethnic and other minority groups (Davison 2000).

Yet revisionist history that focuses on identity in this way can be no less problematic than received history. Without doubt, revisionist history may acknowledge those whose voices have been ignored previously, but its very aim of righting wrongs or locating origins that resonate with the present raises concerns. Revisionist history can be crafted so that it 'fits' with an author's view of the world (Davison 2000, Ulrich 2002). These interpretations can be invested with nostalgia and lack critical and effective analysis of evidence, yet masquerade as history (Ulrich 2002).

Two histories of midwifery, produced during the revival of midwifery in the 1990s, illustrate the effects of an uncritical approach to examining professional identity. The first is an oral history of midwifery in England; the second is a study of South Australian midwifery. Leap and Hunter, the authors of the English study, declare in their introduction that: 'We expected to uncover a treasure chest of forgotten skills: experience that would enhance midwifery practice and inspire the midwives of today' (Leap & Hunter 1993:xi). In the Australian text, Annette Summers examines the 'historical terrain which led to the demise of the community midwife, whose lost autonomy is lamented by the midwife of the 1990s' (Summers 1995:1).

The authors of these texts searched for forgotten skills and lost autonomy, concepts likely to resonate with contemporary midwifery's professional aspirations to distinguish itself from nursing (Grehan 2009a). In setting out to locate what the authors believe to be a preconceived history, these inquiries mimic the history of received nursing's pursuit of Nightingale-style nurses and their mythical transformation of healthcare. Leap and Hunter, for example, concluded that there was no evidence to

suggest either that handywomen were dealing out 'death and destruction' to pregnant women or that handywomen midwives were involved in performing abortions (Leap & Hunter 1993:22).

Their conclusion runs counter to ample documentary evidence in England confirming that some untrained women, as well as trained midwives, were ill-equipped (as were many doctors) for even the most common of complications in labour, such as haemorrhage. Ample evidence exists, too, of female midwives in England and elsewhere, facilitating crimes of abortion and infanticide (Grehan 2009a). Likewise, Summers locates midwifery's 'lost' autonomy in South Australian midwifery at a time before the profession of nursing eclipsed this 'ancient' form of women's practice. This work ignores extensive documentary evidence of midwives' roles in abortion and infanticide, and evidence that some women lacked basic skills at bedsides (Grehan 2009a). It is no surprise that these authors for the most part find the history they expect to, because neither inquiry applies the self-consciousness of critical history.

Applying criticism of these revisionist histories is not to suggest that independent midwifery was not extinguished, nor is it to suggest that medicine and nursing did not wish to institute control over midwifery as it was practised by women. But history, even misinformed history, can have an impact on the fundamentals of a professional identity and be influential in making special claims for status and privilege on that basis. Thus, it is critical for nurses and midwives to be conscious of how all of the histories of nursing have been constructed, and to understand the motivations of those who write them. For those willing to investigate the history of nursing from the perspective of critical history, the rewards are great. In the next section, we raise some aspects of New Zealand's and Australia's nursing and healthcare history, which are worthy of critical inquiry.

Religious nurses

We can be forgiven for believing that no skilled nurses worked in Australia or New Zealand in the nineteenth century, because of the powerful and longstanding narrative that ignorant and incompetent nurses were those in practice until the arrival of 'Nightingale' nurses in 1868. But there were many with qualifications and/or skills. Aside from midwives whose claimed training and qualifications have been confirmed (Grehan 2009a), the Catholic Sisters of Charity have a long history of care provision in Australia. As early as 1838, five religious sisters from Dublin were providing care in Sydney. Of these five, one had trained as a nurse and another had been sent to Paris to gain nursing experience (MacGinley 2002). The Sisters visited 'the sick poor in their own homes' as well as Parramatta's female factory or gaol where miscreants served their sentences (MacGinley 2002:72). In 1857, the Sisters of Charity opened the first St Vincent's Hospital in Australia, at Sydney's Potts Point. Since that time, the St Vincent's network has expanded substantially, with their hospitals providing a considerable proportion of public health services.

The St John of God Catholic Sisters cared for typhoid sufferers in isolated settlements in Western Australia and those affected by leprosy; the Sisters of the People, associated with the Methodist Church, tended the indigent in cities (Grehan 2008). In New

Zealand, too, Christian-based sisterhoods and other organisations tended the sick and dying (Sargison 2001). In 1896, a committed Anglican and trained nurse, Sibylla Maude, established a district nursing service in the South Island of New Zealand (Sargison 2001) which continues today. The role of religious or faith organisations in nursing and nurse training is one of the most interesting and challenging topics in Australia's and New Zealand's nursing history because it encompasses aspects of gender and colonisation. Two Christian religious groups with enormous influence on Australian nursing are the Presbyterian Church and the Salvation Army, for their pioneering of nursing provision to remote communities in Australia.

The Australian Inland Mission

The Australian Inland Mission (AIM), an offshoot of the Presbyterian Church, was another form of charitable assistance to rural and remote communities, devised in the early twentieth century. With others, the Reverend John Flynn, of the Flying Doctor fame, established AIM centres, staffed by trained nurses in extremely isolated territory (Cockrill 1999). In the AIM's early years, nurses were also deaconesses of the Presbyterian Church, and in this sense were evangelists for health and faith. In AIM centres, the nurses attended patients, conducted Sunday School and offered spiritual comfort to people in their communities (Cockrill 1999).

AIM nurses faced all kinds of challenges because of the isolation in which they worked, particularly before the introduction of pedal radio. Not all nurses were trained in midwifery nursing, yet they were expected to attend births. The Women's Hospital in Melbourne is known to have permitted deaconess nurses to undertake short terms of midwifery 'training' to gain a degree of experience. For instance, Mary Ann Bett was a deaconess and nursing sister recruited to the AIM centre at Oodnadatta in South Australia in 1909 in preparation for which she did a short stint of midwifery training at The Women's (The Women's Hospital Board of Management Meeting Minutes 1909). Sister Jean Finlayson (pictured in Fig. 2.4 on a mode of desert transport) worked at the AIM's Oodnadatta centre and was then inaugural trained nurse at the Northern Territory's Alice Springs AIM Centre in 1915 and later the Alice Springs Hospital (Cockrill 1999).

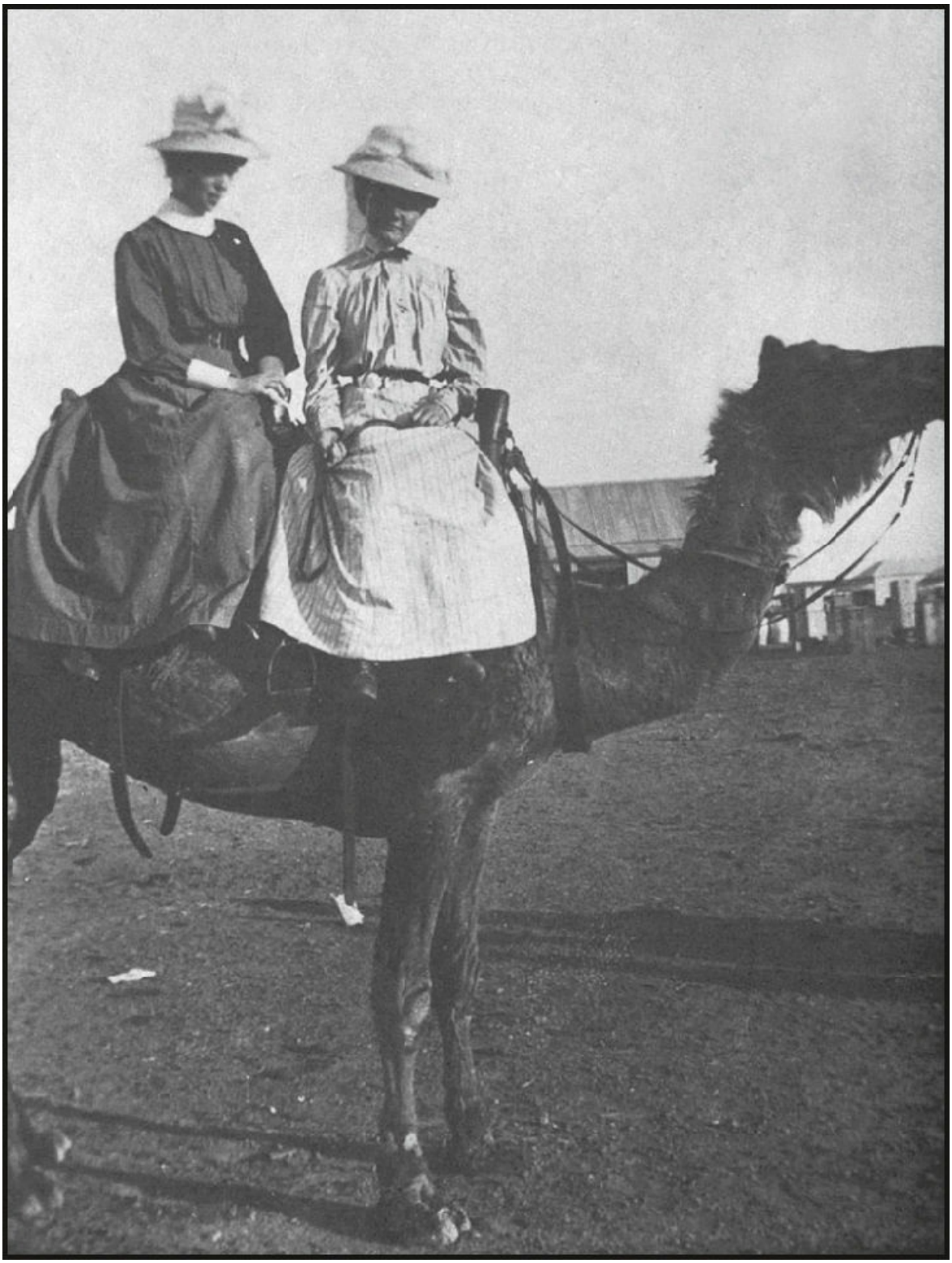

FIGURE 2.4 Jean Finlayson (right) and fellow deaconess at Alice Springs c1915 *Source: Adelaide House Museum and Alice Springs Uniting Church.*

Aboriginal nurses

Mainstream hospitals were reluctant to accept Indigenous women as pupil nurses, at least until the mid-1950s, whereas the Salvation Army, a Christian organisation with a network of hospitals around Australia, did accept Indigenous pupils from missions. Bethesda was a Salvation Army hospital in Melbourne with a recognised nurse training school (Grehan 2008).

Miss Sadie Corner (see Fig. 2.1, page 17) moved from Mount Margaret Mission to train at Bethesda in the 1950s, firstly as a nurses' aide, then as a general nurse, and later as a midwife. Miss Corner is believed to be the first Aboriginal woman to work as a trained nurse and hospital matron in Western Australia. As Mrs Canning, Sadie was awarded an MBE (Member of the British Empire) and a Queen's Jubilee Medal for her contribution to the health of the community of Leonora and surrounding district (Australian Legal Information Institute 2000).

As a two-year-old, Lowitja (Lois) O'Donohue CBE, AM, from South Australia, was removed from the care of her mother and sent to Colebrook Home in Quorn. O'Donohue's initial application for nurse training was rejected because she was of Aboriginal descent. Subsequently, she was accepted and graduated from the Royal Adelaide Hospital in 1954 as a general nurse. O'Donohue worked in Adelaide as a charge sister and later spent time in India with a missionary society, before taking up positions in national Aboriginal affairs (State Library of South Australia 2001).

Research by Odette bib80">Best (2015), an Indigenous nurse from Queensland, is extending knowledge about Australian Aboriginal women with training in nursing. For example, a 'Native Nurses Training Scheme' existed on three of Queensland's mission stations in the 1940s. This scheme was implemented because white trained nurses were not attracted to work with Aboriginal people. Best's research has also uncovered several Aboriginal women who undertook hospital-based midwifery training well before the 1950s.

The New Zealand experience was somewhat different. Scholarships for Māori women to train as nurses were available in the 1890s and by 1905 the training took three years (Bryder 2015, Wood 1992). The government then introduced a Native Health nursing scheme designed to improve the health of Māori populations living in isolated areas. Trained Māori nurses and midwives were to be offered positions first, and then white nurses if those places could not be filled. Bryder (2015) reports that the work was challenging for both Māori and white nurses who dealt with difficult clinical problems and had little support.

This emerging scholarship demonstrates a nexus between faith organisations and nurse training programs for Indigenous women. The colonial and post-colonial history of faith nursing is worthy of further research, as is the pivotal role of faith organisations in buttressing the rural and remote nursing workforces in Australia and New Zealand. Equally, governments' forays into devising and implementing training schemes as public health measures is worthy of critical inquiry.

The future

At the beginning of this chapter, we proposed that sometimes history can offer insights about the future. It is impossible, of course, to tell what the future will bring, so we can

be guaranteed that the future is uncertain. An understanding of history can tell us what is *unlikely* to happen, rather than what *will* happen, simply because history never repeats itself (Davison 2000). Over a sweep of time, history can reveal consistencies and patterns that emphasise the perennial nature of fundamental challenges.

Perhaps the most striking consistencies in the history of nursing, at least in Australia, are the problems of attracting recruits to study nursing and retaining their services in nursing. Nursing has been affected by chronic and acute shortages of personnel since Europeans arrived in the colonies. Shortages have prompted reforms in education and training. During wartime in Australia, they have provoked government intervention to control the supply and movement of nurses (Grehan 2009). Shortages have led to governments in the past to recruit nurses from other countries and to create new tiers of care attendant. Shortages are an enduring problem in nursing and there are no quick fixes to solve it. In the face of this perennial concern, it is likely that any solutions proposed will be new iterations of old ideas: changing education programs, creating new categories of nurse, or adjusting the public's expectations of what a nurse is and what a nurse does. Governments will continue to bolster the nursing workforces in New Zealand and Australia through skilled migration schemes. It is even feasible that governments may manage nursing shortages by invoking controls over the profession, just as Australia's Directorate of Manpower did during World War II. Circumstances where this is foreseeable are public health emergencies such as outbreaks of influenza.

A second trend which is likely to continue into the future is the shift in locus of care. In the late nineteenth century, the primary domain for care changed from the home to the modern hospital. In recent years, it has returned to the home where patients can receive sophisticated treatments that were performed previously in hospitals. A continuation of this trend is likely as costs for in-patient health services balloon and as efforts are made to keep people well and healthy and out of hospitals. In fact, one area where the trend from hospital to community-based care may escalate is aged care, as people live longer and are encouraged to 'age in place', for most meaning their home.

Trends guaranteed to characterise nursing in the future are the role of technologies of care and changing understandings of life, death, health and illness. As philosophies and technologies evolve, nurses in practice will need ongoing education to stay up to date. Technology is generally recognised as beneficial, yet attracts criticism too. Since the introduction of the thermometer in the nineteenth century, technologies of all kinds have been blamed for producing a 'mechanistic' nurse, one focused on machinery at the expense of delivering basic care needs. These concerns are likely to persist given technology's dominance in the scope of nursing practice. Another guarantee is that arguments about professional identities will continue and possibly strengthen. The movement to separate midwifery from nursing might encourage other branches of nursing to pursue a similar path. Psychiatric nursing had its foundations in asylums, geographically and philosophically separate from general hospitals and general nurse training schemes. Yet structural service and educational reforms later positioned psychiatric nursing as a postgraduate specialty of nursing. Just as contemporary midwifery has advanced regulatory independence from nursing based on its historical differences, so may psychiatric nursing draw on its history to argue its separation from

nursing.

CONCLUSION

In this brief overview of the history of nursing in Australia and New Zealand, there are many aspects of nursing history worthy of examination, using the tools of critical history. Some have been mentioned: women combining nursing with their evangelical missionary work, the role of Aboriginal women as nurses, migrant nurses and aspects of nursing practice—that is, doing, organising, planning and implementing the care of others. More historical inquiry will illuminate the background to contentious areas in the history of nursing, such as the relationship of nursing with midwifery and the care of women. Research on the impact of world events and globalisation on nursing may provide clues about how to deal with workforce shortages. What is important for nurses and nursing is to accept its past 'warts and all', celebrating ordinariness alongside triumphs (Nelson 1997:234). The pursuit of critical history will provide a realistic vision of the history of nursing in the Australian and New Zealand context, one that factually illuminates the richness and complexity of that history.

REFLECTIVE QUESTIONS

1. How does knowing about the history of nursing help nurses to understand the profession's place within healthcare systems today?
2. What have been some of the major historical influences on nursing and midwifery?
3. What new questions could be asked about the history of nursing?

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CHAPTER 3: NURSING AND SOCIAL MEDIA

Caleb Ferguson

KEY WORDS

digital nursing; e-professionalism; ethics; professionalism; social media; social networking; technology; Twitter chat

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- define social media and describe a variety of applications for nursing practice;
- describe how social media interfaces with nursing across practice, education, research and policy;
- apply regulatory policies and guidelines for social media use and discuss their implications for nursing;
- describe ethical and professional issues for nurses to consider when using social media in practice;
- contemplate the future innovations and horizons for social media and nursing.

INTRODUCTION

Communication is a vital aspect of human interaction. On 10 March 1876 Alexander Graham Bell invented the telephone, sparking the advent of a new telecommunications industry. Within today's society, the internet is a critical piece of communication infrastructure for many people, and therefore denying or restricting access, while hospitalised for example, is failing to address people's needs. In today's world, the internet is a central element of daily life, and has replaced the telephone as the main source of communication. The face of the internet is constantly evolving, and social media platforms are rapidly changing living landscapes. Web 2.0 describes a change in the way humans interact with information online. Since the inception of Web 2.0 we have witnessed internet users adjust from being passive recipients of web-based content to active creators and curators of digital content (Ferguson 2013). Social media platforms are wide ranging and include Facebook, Twitter, LinkedIn, Google+, YouTube, Instagram, Pinterest and Snapchat to name a few. Users of these platforms can actively create their own content by posting and uploading photos, sharing content, 'liking' or blogging information and ideas. Social media is an umbrella term that includes social networking (such as LinkedIn), content sharing (such as Instagram), web publishing (such as blogging and micro-blogging) and wikis (including Wikipedia) (Department of Education and Early Childhood Development 2013). While nursing has been relatively slow to take up these innovative tools and the social media boom, the potential application within nursing practice, policy, education and research is extremely far reaching and should be embraced (Ferguson 2013). However, social media should be approached with risk at front of mind. Nursing remains one of the most risk-averse professions, and rightly so, as we are charged with caring for vulnerable individuals. Therefore, it is important that when applying social media to nursing practice, this is carefully risk managed and assessed for appropriateness in practice.

There is a vast array of novel examples of social media application in nursing. These include online support blogs for individuals living with atrial fibrillation (AF), stroke survivor support groups on Facebook and social media-facilitated journal clubs and Twitter chats for nursing researchers and clinicians to name a few. An extensive and diverse range of platforms continue to emerge. However, it is important that nurses have a basic understanding of social media and its implications for nursing practice within the context of the contemporary healthcare system.

What is social media?

The Australian Health Practitioner Regulation Agency (AHPRA) defines social media as 'online and smartphone platforms that people use to share information, opinions, experiences, images, video and audio clips and includes website, and applications used for social networking' (AHPRA 2014a). Its use is prolific and is globally widespread. In 2019, more than 100 billion messages and over 1 billion stories were shared every day

on Facebook (http://newsroom.fb.com/company-info/). Wikipedia is another highly useful and easily accessible platform. In Australia, over 21 million users (85% of the population) are connected to Wikipedia (https://stats.wikimedia.org/wikimedia/animations/wivivi/wivivi.html). Nurses are increasingly using Wikipedia as a rapid source of evidence base at point of care delivery (von Muhlen & Ohno-Machado 2012). While it is pleasing that nurses are consulting the evidence base at the bedside, the scientific and clinical accuracy of this information must be approached with caution (von Muhlen & Ohno-Machado 2012). It is important to critically appraise this information using a systematic approach, as we do with other types of evidence and research. Social media is used widely by undergraduate student nurses (Usher et al 2014). A recent survey of health professional students that examined media preferences for sourcing information revealed that online media is the preferred source of information, well above traditional peer-reviewed journals. Study findings also highlighted that most students preferred Facebook, while Twitter use was reported as comparatively low (Usher et al 2014). These findings further strengthen the argument to embed and augment social media platforms such as Facebook within clinical practice and the higher education setting as valid tools for healthcare interaction, and clinician and patient education.

Relevance to nursing and modern healthcare

Web 2.0 has infiltrated the nursing profession and has broad applicability to nursing practice, research, education, leadership and engagement with the broader community. The potential to informally and formally connect patients and providers with quality health information and health professional support is powerful. Web 2.0 extended into the healthcare arena as consumers and patients seeking health information began disseminating their experiences and knowledge via online platforms (Hutchinson & Jackson 2014). Social media is an easy way for patients and consumers to seek and share health-related information. Clinicians may often use social media to seek and disseminate information. Sixty-one per cent of American adults seek health information online, and more than 37% have accessed user-generated information via social media (Scanfeld et al 2010). This information may be useful for patients and consumers in shaping values, preferences and opinions on relevant healthcare decisions and to increase understanding of treatment choices. Research evidence, the patient's own values and preferences and the clinician's own expertise, are three core components in the provision of evidence-based care (Cullum et al 2017, Hoffman et al 2017). Increasingly, social media platforms including Twitter and Facebook, are being used as a method for research dissemination and engaging in scholarly discussion, as methods of curating, sharing and disseminating evidence for healthcare (Jackson et al 2015, Java et al 2007). In recent years there has been a rapid uptake of Twitter, in particular by nursing academics, to network, share ideas and common interests, promote scientific findings and engage both clinicians and consumers (end users) or their research. Another example of how social media can be used to raise awareness and increase engagement is the Nursing Now campaign #NursingNow, a three-year global campaign (2018–2020), that seeks to improve health by raising the profile and status of nursing,

globally. The campaign is led by the World Health Organization and the International Council of Nurses.

Nurses are required to provide evidence-based care, informed by the most credible research findings. Our codes of professional conduct and regulatory bodies mandate this. Despite this, within many contemporary clinical practice settings, these prolific and pervasive components of the internet (such as Google, YouTube and Facebook) remain blocked by hospital IT server administrators. This is often as a result of highly sophisticated cyber-security attacks such as the well-known 2017 WannaCry cyber-attack on NHS systems that cost the NHS over £92m (*Telegraph* 2018). However, lack of access to social media portals and internet remains a key barrier to nurses accessing the latest evidence base at point of care delivery in some regions of Australia and New Zealand (Bogossian & Kellett 2010). Nurses need to be trusted with the internet. To date, several hospital and health service policies have been developed as a result of many previous matters of misconduct relating to nursing and social media, reported through the media (see Fig. 3.1) Importantly, these policies have failed to consider the growing research evidence that demonstrates a positive influence on patient, provider or health system outcomes (Smailhodzic et al 2016). To gain trust and leverage benefit we must ensure that our online behaviour is maintained to high standards and remains at all times within professional boundaries.

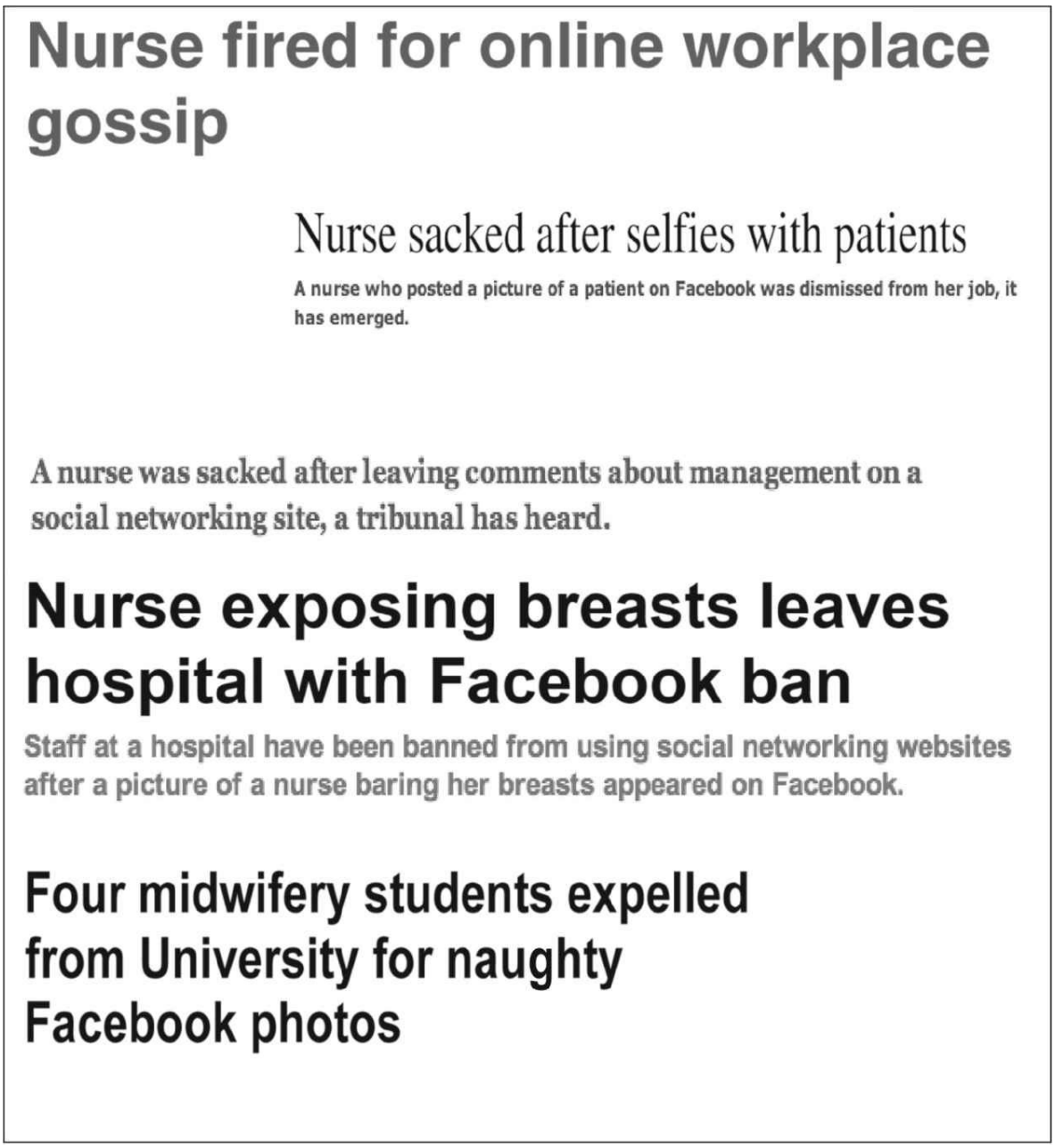

FIGURE 3.1 News reports of nursing misconduct related to social media

At a patient level, it is important to recognise the role that social media plays in many patients' lives. It offers a means for social support that can sometimes be overlooked in clinical practice, particularly when a patient is experiencing ill-health or during hospitalisation for an acute episode of chronic illness when stress and the need for social support are likely increased. Hospitals should progress to develop IT solutions and offer patients reliable Wi-Fi services while in hospital. For example, for families of children in paediatric care, hospitalised with an acute illness, having access to social networks such as Facebook or Instagram may provide vital social supports with coping and adjusting to hospitalization and help in recovery. Nurses ought to treat social

media interaction with similar respect to visiting hours, and value the vital social support provided from family and friends over social streams.

Social media ethics and e-professionalism

E-professionalism is a term that is used to describe professional conduct and integrity that encompasses the traditional definition and values of professionalism and extends to the digital environment (Cleary et al 2013). Today, the ethical principles of beneficence, non-maleficence, justice, respect for autonomy, fairness, truthfulness and justice (as outlined in Chapter 8 'Ethics in nursing') extend far beyond the hospital walls and into the digital world. Nurses must be cognizant of this and maintain professionalism when identifying as a nurse within the digital world. Frequently, the boundaries between professional and personal are challenging to navigate. Yet, nurses are required by their regulatory agencies and employers to act in a professional manner and uphold high moral and ethical standards.

In 2014, AHPRA (2014b) published a mandate that nurses using social media should ensure that they only publish or post information that:

1. does not breach professional obligations

2. does not breach confidentiality and privacy obligations (including discussing patients or posting pictures of procedures, case studies, patients or sensitive material)

3. is not biased and does not make unsubstantiated claims

4. does not use testimonials or purposed testimonials in any capacity or any medium.

Guidance, policy and regulation

Cleary and colleagues (2013) provide a number of recommendations for nurses to maintain when using social media (see Box 3.1). These recommendations focus on building awareness of the terms and conditions of different platforms (albeit these are sometimes difficult to read and interpret), working within professional boundaries, codes and regulations, and regular monitoring and evaluation of your own social media activity. These recommendations also highlight the key messages of 'think before you post' and taking 'time out' to reflect prior to posting in relation to professionalism, confidentiality and privacy.

BOX 3.1 Recommendations for nurses using social media

- Be cognizant and proactive about knowing and understanding the terms

and conditions of each of the social media sites that you use. This can often be challenging, given the frequency with which these are updated, but it is important to keep abreast of these updates and review these and their privacy settings on a regular basis.

• Users of social media should consider all posts as public. It's very easy for a private post to become public (such as a 'friend' or connection screen grabbing a post and re-posting it). Therefore, users should adopt a 'time out' strategy and develop a 'think and reflect'-before-you-post attitude. Be careful in crafting posts, as with the written word; this is easily misconstrued, taken out of context and could have both damaging and negative consequences for professional relationships and career prospects.

• Never consider posts to be anonymous.

• It is essential to regularly monitor and evaluate your digital presence. At minimum, a yearly digital presence personal review is recommended.

• Ensure that you are adhering to your professional standards for practice, employer code of conduct and that you are up to date with privacy and confidentiality legislation.

• Do not post content outside your area of expertise, and avoid the use of testimonials (in adherence with new advertising legislation and guidance) (AHPRA 2014a, 2014b).

Contemporary application in nursing

While it has been important to outline nurses' professional and regulatory obligations in relation to social media, it is essential to highlight some of the innovative approaches to integrating social media across the nursing profession. Fig. 3.2 outlines four broad domains where social media is being embedded across: (1) patient support and nursing interventions, (2) patient services and workforce, (3) education and professional development and (4) policy, procedure and research. This chapter will explore these four domains in more detail.

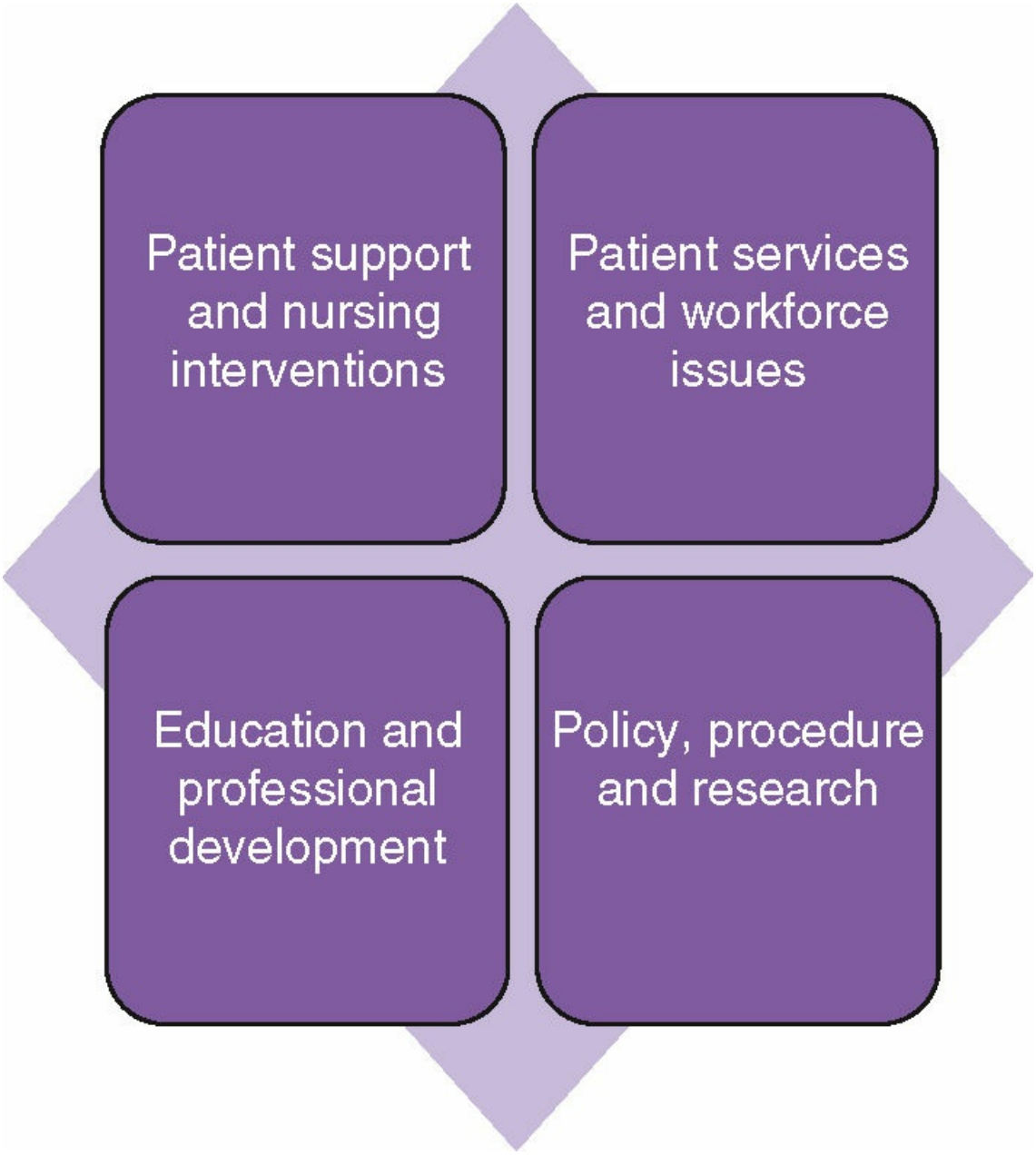

FIGURE 3.2 Key areas for social media innovation in nursing

PATIENT SUPPORT AND NURSING INTERVENTIONS

Social media can be applied in a variety of care contexts, and used as an adjunct to routine clinical care to improve patient support. Further, social media can provide a fun and innovative nursing intervention for patients and caregivers in both acute and primary care settings. We have provided some examples of how social media is presently being used as a nursing intervention and to enhance patient support. These range from using smartphone pplications such as MyFitnessPal, to posting weight loss and fitness achievements to Facebook and receiving positive feedback from friends, to

providing smoking cessation advice in real-time via Twitter. The Stroke Foundation's EnableMe platform is an excellent example of how a closed online support group or blog can be used to share stroke survivor and caregivers' experiences. This can be useful in building an online community of support for patients living with chronic disease, particularly after hospitalisation for an acute event.

More examples of patient support and nursing interventions delivered via social media are described in Box 3.2.

BOX 3.2 Examples of patient support and nursing interventions delivered via social media

• Raising organ and tissue donation awareness (advocating via Twitter, see Fig. 3.3)

FIGURE 3.3 An example of social media advocacy for organ and tissue donation through @DonateLifeToday Twitter account

• Providing ad hoc supportive care for patients and family members via a digital forum

• Assisting with diabetes management (such as blood glucose tracking)

• Maintaining a personal health diary (e.g. posting via MyFitnessPal to Facebook)

• Connecting patients with similar conditions (National Stroke Foundation Australia's EnableMe—online patient community for stroke http://www.enableme.org)

• Providing smoking cessation assistance (ability for real-time feedback from smoking cessation counsellors)

• A platform to engage with exercise training and management

• Receiving 'daily health tips' from credible sources (e.g. secondary stroke prevention)

PATIENT SUPPORT

• Obtaining weight management support (e.g. 'Lark' smartphone application)

• Engaging with epilepsy support groups (such as consumer-driven or NGO-led Facebook page initiatives)

• Engaging with stroke survivor support groups

• Engaging with brain tumour support groups (such as Nurse Consultant-led Facebook groups after discharge post-surgery)

Web publishing, blogging and online communities

Web publishing and blogging allows anyone with access to the internet to digitally self-publish material. This can provide an opportunity for clinicians and patients to share information (Fraser 2011). This can be a powerful tool for sharing stories and experiences relating to clinical practice for clinicians, or experiences of living with health conditions or interactions with the healthcare system from the patient perspective. Online patient communities such as blogs can provide information on a wide range of health-related topics that are of interest to patients, caregivers, clinicians and policy makers. These often lively forums provide a rich insight into the experiences of patients and caregivers, which to date has remained relatively untapped as a way to inform healthcare design and delivery. One example of exploration of an online patient discussion form is research conducted by Vaughan-Sarrazin and others (2014). This research aimed to explore patient experiences and perceptions of pharmacological treatment options for atrial fibrillation. The researchers used a thematic qualitative content analysis method to explore the blog and found five key themes. These include: (1) general concerns about safety and efficacy of pharmacotherapy, (2) questions about indications and contraindications, (3) questions about the proper use and storage of medicines, (4) questions about diet and drug interactions and (5) experiences with perceived side effects of drugs. This study highlighted the significant impact that blogs and online communities can have for patients, in sharing experiences of living with a chronic condition and as an avenue for informal support. Increasingly, nurses are approached by patients and caregivers in clinical practice to recommend websites, smartphone applications and blogs for healthcare information and informal support after hospitalisation. There is need for greater continuing education of nurses and credible instruments to support quality appraisal of these innovations. Furthermore, nurses working within clinical specialties have a responsibility to now keep abreast of credible and endorsed applications, blogs and webpages that have high relevance to

patient care so they can recommend these to patients and caregivers in practice.

Health promotion

Social media is a highly effective tool for health promotion; however, some studies advise caution as they have found that sometimes it can lead to the provision or reinforcement of inaccurate information to patients and caregivers. A recent study by Appleton and colleagues (2014) explored parents' use of online discussion boards for child health information seeking advice and social support. This study found parents' use of this discussion board to be mainly related to (1) seeking advice, (2) sharing advice, (3) social support and (4) making judgements. The authors of this study highlight that while online discussion boards are useful in providing a supportive environment, and provide accurate health-related information, there is opportunity for the unconscious provision and implicit reinforcement of inaccurate health information (Appleton et al 2014).

YouTube is a relatively low-cost health promotion tool that can be helpful in targeting populations (e.g. youth) with key public health campaigns such as cancer prevention strategies and cardiovascular risk reduction messages (Bottorff et al 2014). A study that evaluated YouTube videos that consisted of moving text, novel images, animations and youth-friendly music found these to be interesting to girls and boys enough to report willingness to share these across social media platforms (Bottorff et al 2014). These positive responses in this study highlight the need to develop social media health interventions that are individualised to the target population and to target the appropriate digital platform to have optimal impact on the age demographic of users.

PATIENT SERVICES AND WORKFORCE

Social media is also being used to streamline health service management processes, and improve the operational workings of healthcare facilities. Healthcare recruitment agencies are using sites such as LinkedIn and Twitter to source potential candidates for nursing vacancies. It is increasingly important for student nurses to develop and maintain a LinkedIn profile, to showcase achievements during their degree studies. Other examples of social media supporting patient services and the health workforce range from electronic SMS reminders from clinics, and online web-based and text message shift-booking systems for nurses. Further examples of patient services and workforce interventions that are delivered by social media are provided in Box 3.3. Other closed platforms, such as Yammer, are being used by institutions to help support sharing of information and help build culture across small to large organisations.

BOX 3.3 Examples of social media-delivered patient services and workforce interventions

EXAMPLES OF SOCIAL MEDIA-DELIVERED PATIENT SERVICES

- Patient care reminders in the clinical setting (automated text messaging SMS services for clinic appointments)

- Prescription management, including pharmacy refill reminders
- Coordinating preoperative, peri-operative and post-operative care
- Arranging outpatient care
- Coordinating allied healthcare services during patient admissions
- Coordinating patient discharges across clinical services
- Post-discharge patient consultations
- Case management functions
- Checking hospital ratings with other healthcare consumers (e.g. MyHospital)

EXAMPLES OF SOCIAL MEDIA-DELIVERED WORKFORCE INTERVENTIONS

- Transmitting critical laboratory values to nurses and physicians
- Augmenting telemedicine
- Remote wound care assistance
- Shift bidding for nurses and other healthcare professionals (e.g. CASCOM, which is an online open shift-bidding platform for casual staff that can be accessed via smartphone and desktop devices)
- Recruitment of healthcare staff (advertising on LinkedIn for job opportunities and vacancies)
- Communicating with nursing supervisors

EDUCATION AND PROFESSIONAL DEVELOPMENT

Social media can be an effective tool for educating nurses, and for fulfilling continuing professional development (CPD) regulatory requirements as a registered nurse (Moorley & Chinn 2015). The number of nurses, clinicians and other professional healthcare associations and bodies using Twitter in recent years has increased exponentially (Redfern et al 2013). The 'WeNurses' Twitter chats (see http://www.wecommunities.org) are a new way of engaging other nurses in

professional discussion via social media on a regular basis to engage with contemporary issues in clinical practice, and discuss challenges in practice and evidence-based care. WeNurses was originally developed by Teresa Chinn (an agency nurse from the UK) in 2012, and now has in excess of 50,000 followers (Moorley & Chinn 2014). WeNurses provides an online forum, regardless of geographic location, that is globally accessible to discuss contemporary issues in nursing via Twitter. Twitter chats normally take place weekly, using a structured format for one hour, and with support from a skilled moderator. They are wide ranging in topics from clinical handover, pressure injury risk assessment and management, to infection prevention, technology and student nurse bursaries. Participants in the chats have reported a sense of community with nursing, and the benefits of keeping abreast of developments in nursing, and as an avenue for support and friendship. Other participants report that it is a great way to share information and knowledge, meet new contacts and debate and challenge evidence and practice (Moorley & Chinn 2015). WeNurses can be found on Twitter (www.twitter.com/wenurses) @WeNurses, (http://www.wecommunities.org/) and use the hashtag #WeNurses to categorise tweets during their weekly discussions (Moorley & Chinn 2015).

Twitter chats

Twitter chats can be helpful to engage clinicians with evidence or support a community of practice around particular issues. Wright and colleagues (2020) recently developed and evaluated a Twitter chat focused on raising awareness on antimicrobial resistance (AMR) with research students. Twitter was selected as the optimal platform due to its outward facing nature and given it has been successful in creating communities of practice such as #WeNurses. The Twitter chat was hosted and convened over a 24-hour period. After 72 hours, the team identified that over 2.6 million accounts were researched and over 10 million impressions achieved. This is impressive in reach, impact and engagement. Such studies highlight the utility of Twitter chats to create conversation, awareness and shine a light on topics of popularity, at fairly low cost. Further, Twitter has the potential to bring a global nursing community into a classroom to engage with students and reflect and discuss key nursing-related issues (Wright et al 2020).

Development of clinical skills

Social media can be a very helpful tool for learning. Increasingly, nurse teachers recognise that students learn outside traditional learning environments such as the physical classroom and the clinical environment. New pedagogical approaches to nurse education including blended and flipped models are increasingly common and driving an increase in the embedment of social media and other digital technologies within nurse education, both in the undergraduate and postgraduate curriculum. The ease of access and instantaneous nature of social media make it an adaptable learning resource. An emergent area of interest among clinical teachers is its application in the development of clinical skills in novice nurses. Students are also referring to YouTube as a quick way to refresh knowledge on elements of clinical skills. A key driver is the

rapid access to visual and video information, yet academics recommend caution and quality assessment of online resources to check for their quality and credibility (Duncan et al 2013).

While virtual worlds may not be considered as 'social media', such social-digital platforms also hold promise in the nurse education world. There has been great hope for increasing the authenticity of user experience as these platforms have developed and become more clinically relevant in recent years, with increased quality of software. Augmented and virtual reality social applications, including INGRESS, ZOMBIES RUN! and Wii Fit, are novel examples of healthcare interventions that can be utilised as part of a health program to increase patients' levels of physical activity (Ferguson et al 2015). Nurses should consider embedding augmented and virtual reality and serious game applications in routine clinical practice. These apps can be helpful in engaging patients in activities through game theory. It is important for clinicians to carefully consider gaming interventions such as social media and other digital applications as part of a variety of tools that can be adopted in practice. However, these require careful selection and evaluation, and should be considered based on an individual patient's needs as part of a patient-centred care plan (Ferguson et al 2015).

The following are some examples of how social media is being used as a tool to enhance learning and education in both pre-registration programs and for continuing professional development. WeNurse Twitter chats are an excellent example of a professional activity, hosted and facilitated through Twitter, that can contribute to continuing professional development, regardless of geographic boundaries. Further examples of social media-delivered education and professional development are detailed in Box 3.4.

BOX 3.4 Examples of social media-delivered education and professional development

- Clinician opinion-sharing via short tweets and twitter conversations
- Example NCLEX (National Council Licensure Examination) test questions for preparation for nursing registration in the USA (see Fig. 3.4)

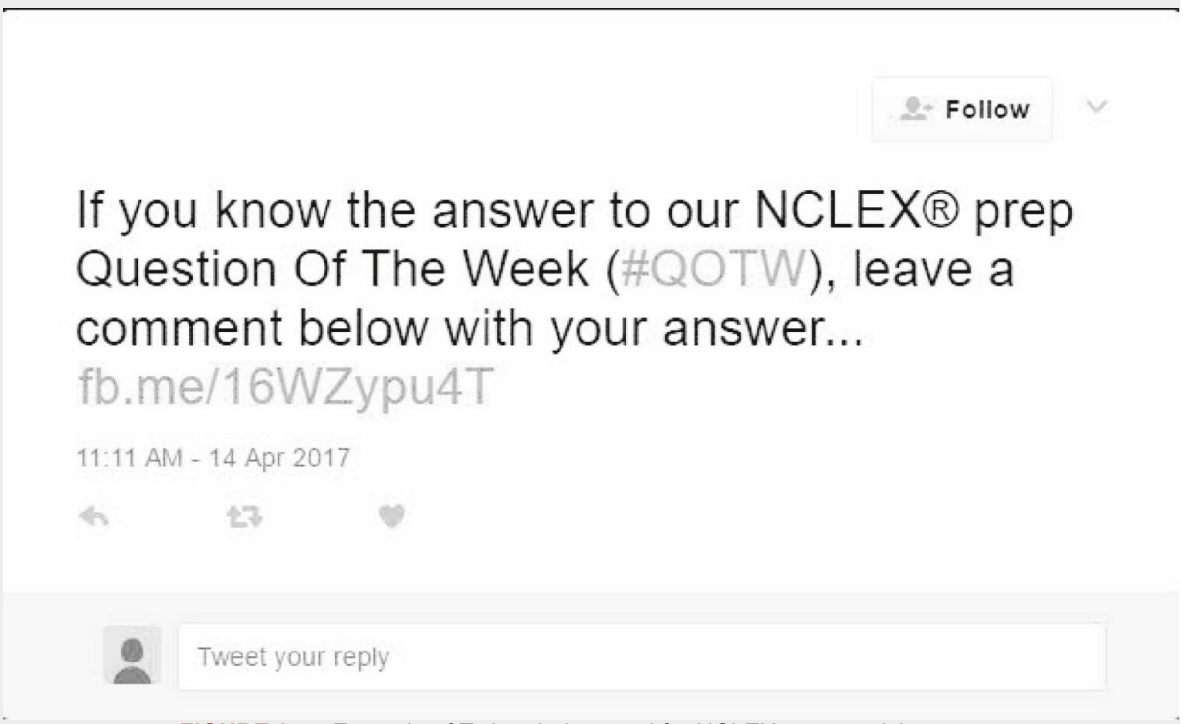

FIGURE 3.4 Example of Twitter being used for NCLEX exam revision

- Reviewing evidence-based byte-size education for clinicians
- Providing an avenue for nurse–mentor relationships and collaboration
- Live-tweeting surgical procedures for education (Watch: https://www.youtube.com/watch?v=LZycUg4OGhI)
- Live-tweeting nursing conferences and meetings (Example #PCNA2016; Preventative Cardiovascular Nurses Association 2016 Conference, Orlando, April 2016)
- Connecting genetic and basic science/bench researchers with clinicians

POLICY, PROCEDURE AND RESEARCH

Many researchers are also reaping the benefits of social media as a tool for enabling and conducting nursing research. The global reach and viral ability of social media make it an adept tool for recruiting research participants and enabling the link to information about upcoming studies and disseminating research findings. Recently, Mannix and colleagues (2014) described their experience of using social media for research participant recruitment and data collection via an online survey. Their work highlights that social media can be useful for nursing research purposes and can be helpful to gain global perspectives on nursing issues throughout the world, as opposed to local insight

into issues at a single ward or hospital level. Social media presents a low-cost, pragmatic and creative method to conducting nursing research (Mannix et al 2014).

Social media is being embedded within health policy and adopted for public health procedures. Its utility and importance to facilitate with nursing research is being increasingly recognised. This ranges from basic peer sharing of useful journal articles, to engaging with researchers in real time, and as a method of recruiting and engaging with research participants. Other examples of how social media is being adopted in the areas of policy, procedure and research are outlined in Box 3.5.

BOX 3.5 Examples of social media integration across health policy, procedures and research

POLICY AND PROCEDURE

- Adverse event reporting in the clinical setting
- Drug safety alerts from the Therapeutic Goods Authority (TGA) or new listings on the Pharmaceutical Benefits Scheme (PBS)
- Tweeting updates on facility policies and safe operating procedures (local health districts and hospitals dissemination to employers via platforms such as Yammer)
- Issuing emergency updates to hospital services to the general public
- Clinical education coordination (updates to employees about upcoming educational events, such as opportunities to achieve mandatory training requirements)

COMMUNICATION

- Rural area healthcare communication (providing back channel moderated Twitter chat to augment an interstate metro-rural education web conference)
- Publishing health-related news
- Tracking evidence-based guideline updates

NURSING RESEARCH

- Clinical trial awareness (updates to clinicians on clinical trial recruitment targets)

- Research finding dissemination
- Sharing peer-to-peer reviews of articles of interest
- Generating streams of authoritative healthcare content online
- Discussing public healthcare policy
- Developing stronger patient-provider-researcher relationships

Social media-facilitated journal clubs are becoming popular among nursing specialties. One example of this is the European Journal of Cardiovascular Nursing (EJCN) Journal Club (see http://cnu.sagepub.com/site/additional/JournalClub/Articles.xhtml).

This is a social media-based journal club facilitated by an expert moderator (usually a journal editor), and co-hosted by an author of a recent publication from that journal. The social media journal club is hosted on Google+ Hangout. This provides a unique opportunity for clinicians and the journal readership to directly engage with the researchers and authors of clinical studies (Jackson et al 2015). At the time of writing, the EJCN have hosted four sessions, and these are also recorded and then uploaded onto YouTube at a later stage for people to view, if they were unable to attend the live session. This innovative approach to technology-enhanced journal club offers is exciting, and removes geographical challenges to engaging in such scholarly activities. These initiatives may assist with the uptake of evidence to practice (research translation), and also overall improve research appraisal skills in the nursing profession.

STORY

You are working as a new graduate registered nurse in a busy acute surgical ward in a major metropolitan teaching hospital. You are caring for Hayley, a 23-year-old female patient who has recently been involved in a road traffic accident and has fractured her neck of femur. You are administering an injection to her. While obtaining Hayley's consent for a subcutaneous injection, and checking the five rights of medication administration, Hayley asks you if she can record and live broadcast a short Facebook video of her injection to her friends using her smartphone. Hayley's mum is also present at the bedside, and thinks this would be pretty 'cool' to do too, and is keen to assist in recording this video.

Reflective questions

1. What would your nursing actions be in this scenario?

2. How would this interaction with Hayley affect your therapeutic relationship with her?

3. What could the professional repercussions of your actions be if you allow Hayley to record and broadcast this procedure?

4. What are important factors of consent in this scenario?

STORY

You have been working for three years in the general medical ward of a regional hospital. During this time, you have received many 'friend requests' on Facebook from your nursing colleagues in the ward, which you have accepted. You have had a busy morning shift, and were short of staff and acuity of patients was unexpectedly high. That evening you log onto Facebook at home, and see a post from a colleague that you were working alongside that morning. She is venting about the terrible shift she had experienced, makes note of the intensity of the workload and is insulting and offensive to other colleagues from your unit.

Reflective questions

1. What reaction would you have to your colleague's post?

2. How would you approach your colleague both online and offline?

3. Would you report this behaviour to your nurse unit manager?

CONCLUSION

Social media is highly relevant to nursing practice, policy, education and research. It provides a platform for patients to engage with professionals and seek support or outreach for centres with limited access to expert input from specialist centres and professionals. Nurses must consider social media as a method to remain abreast of the nursing science and as an approach to continuous professional development. All nurses have a professional obligation to report unprofessional use and misconduct. Novel methods of communication and information sharing will allow nurses to apply evidence to practice without some of the technological barriers that exist today. Nurses must leverage social media and learn to adapt to its complexities. Social media platforms can be highly effective platforms for healthcare when used appropriately. It is important that all nurses are adept in the use and application of technology within the contemporary healthcare system.

REFLECTIVE QUESTIONS

1. What application do you think social media has for nursing in modern society? What are the potential advantages and disadvantages for the discipline and profession?
2. How do you think social media may be used in patient and caregiver education and in making decisions related to healthcare choices?
3. What constitutes unethical professional conduct on social media for nurses?
4. How would you respond to professional misconduct if you witnessed a friend or colleague use social media in an unprofessional manner?
5. What guidance or policy documents are available to support you in using social media as a nursing tool in a safe and effective manner?

Recommended resources

Nursing and Midwifery Board AHPRA. Social media: How to meet your obligations under the National Law. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Social-media-guidance.aspx.

We Communities – Resources and social media guidance. http://www.wecommunities.org/resources/links/guidance.

Twitterversity for student Tweeters. http://www.wecommunities.org/resources/twitterversity1.

Nursing and Midwifery Council (NMC) Guidance. Social media do's and don'ts. http://www.nursingtimes.net/roles/nurse-managers/nmc-guidance-dos-and-donts-for-social-media/5032912.fullarticle.

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CHAPTER 4: KEY CONCEPTS INFORMING NURSING: CARING, COMPASSION AND EMOTIONAL COMPETENCE

Stacey Wilson

KEY WORDS

care; compassion; emotional; competence; empathy; engagement; holism; humanism; person-centred; science and art; self-awareness; theory

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- consider caring in nursing as an art and as a science;
- discuss caring in the context of professional nursing and being a nurse;
- explore the concept of compassion and its relevance to social relationships in nursing;
- describe 'compassionate outrage', public demand for better care and consideration of contemporary threats to effective caring and compassion;
- discuss developing emotional competence in nursing through self-care and self-compassion.

INTRODUCTION

Much research has been devoted to exploring the ethical and communicative conditions of professional nurse encounters of caring. The status of ideas and theory require in nursing an ongoing need for critical reflection despite existing guidelines, competencies and skills, which have developed over time. In nursing we speak about people as unique or autonomous, a fixed identity in their own right. As a result, when we talk about our encounters with people or their families or others in the healthcare setting, we describe a coming together of two or more people each with their own identity. Explanations of nursing work are laid down in guidelines about how people should meet each other in a professional nursing context, presupposing that identities remain the same. However, every encounter is unique in place and time and consequently is not an abstract reality of a separate patient and nurse, but always concerns an act and praxis within social, economic, cultural and political contexts.

When I ask new nursing students what has influenced their decision to enter nursing as a profession, it is a two-fold question: Why nursing for you and what is on offer for nursing from you? Students often speak of an important person in their life who was a nurse and account their motivation to learn based on the contribution of that important person to people's wellness and comfort, including theirs. Students also offer that they are motivated by being 'people-orientated', like working with others, value health and helping others and want to make a difference. The second part of the question is harder for them to readily share. Possibly this is because their perceptions of nursing have been shaped by the complexities of relationships with others, their own health status and the popular public portrayal of who a nurse is. Nonetheless we all bring with us our own histories, and during the encounter of learning, work on the structures that enable theory-informed practice to develop.

REFLECTION

What or whom has influenced your decision to become a nurse?

Nursing as art and science

Theories offer ways of understanding and explaining the happenings, events and trends of a social profession such as nursing. A united philosophical premise of nursing theories is that the social world in which we live is brought into being through practices. Structures that house current thinking about nursing need to be considered as ongoing constructions that are built and rebuilt continuously through relationships and in context.

SCIENCE AND NURSING

The science of nursing has historically been aligned with knowledge relating to people's bodies and minds and the authority of medicine (see Box 4.1). Early healthcare delivery, such as in hospitals in the late nineteenth and early twentieth centuries, was driven by

and belonged to medicine and doctors. Medicine has been a powerful and dominant discourse throughout our nursing history. Certainly, it can be seen that a scientific discourse such as medicine has almost unlimited authority derived from the ways in which it is made authoritative (Busfield 2017). Powerful discourses become so because of their embeddedness in significant institutional bases. The centrality of medicine to any public discussion of health means that it is that overarching belief system that positions consumers of healthcare delivery.

BOX 4.1 A snapshot of New Zealand and Australian nursing history

For a timeline of nursing history for both New Zealand and Australia, the following resources are recommended:

- History of Nursing in New Zealand (Health Times 2019): https://healthtimes.com.au/hub/nursing-careers/6/guidance/nc1/history-of-nursing-in-new-zealand/515/

- History of Nursing in Australia (Nurse Uncut: Dr Georgina Willetts): https://www.nurseuncut.com.au/from-nightingale-nurses-to-modern-profession-nursing-in-australia/

- Timeline of nursing history in New Zealand and Australia (Retrieved on 1 October 2019 from https://www.revolvy.com/page/Timeline-of-nursing-history-in-Australia-and-New-Zealand?cr=1)

Discourses refer to the knowledge, strategies and practices that underpin and legitimise certain ways of acting and being.

Nursing, historically, was regarded as inferior to medicine, and nursing knowledge and skills were subservient to the doctors' instruction and oversight. Nursing was, and is still, largely undertaken by women and ideals of womanly virtues, and the exercise of womanly arts, promoted a strong and lasting picture of what a nurse is in the minds of the public. The development of modern Western nursing as a profession began with hospital-based training through the Florence Nightingale school of thought, through to the current status of university-based nursing across the world (Patestos et al 2019).

Hospital-based training was a process of systematically instilling a task-orientated set of practices and the moulding of a set of attitudes to produce nurses who exemplified the feminine stereotype. Obedience and trustworthiness were expected as key characteristics of the nurse as she bathed the sick, made their beds and comforted them. Knowledge of science and inclusion within nurse training was seen as unnecessary. Hospital-based training, developed initially by the Nightingale school of thought, was implemented throughout Commonwealth countries including Australia and New Zealand and lasted up to the early 1970s when education for nurses was radically moved from healthcare institutions to educational facilities located in universities and

polytechnics.

University education for nurses happened well before this in the United States in 1919. Within the US education system nursing developed into a theoretical and scientific basis of practice and by the 1950s programs for training nurse scientists were established. According to Parker (2014), 'In the period from the late 1950s to early 1980s, theories of nursing proliferated as nurse scholars sought to include in the concepts of nursing an understanding of biological, behavioural, social and cultural factors in health and illness' (2014:43). The production of systems of thought through nursing theory and the creation of nursing science was in conflict, however, with ideas about the art of nursing, and separate debates about the art and science of nursing began.

With the relocation of nursing to tertiary education, modern nursing began to be shaped as a profession and delineated by a separate body of knowledge. The goal of securing professional status for nursing meant the need to establish a unique scientific basis of knowledge and one that was separate from medicine. The quest for nursing science included the significant task of distinguishing medicine from nursing and the consideration of the art of nursing in relation to humanism and the nature of the human subject. This is a key philosophical assumption, which underpins nursing research and practice, and illuminates the difference between medicine and nursing as related but intrinsically different applied disciplines.

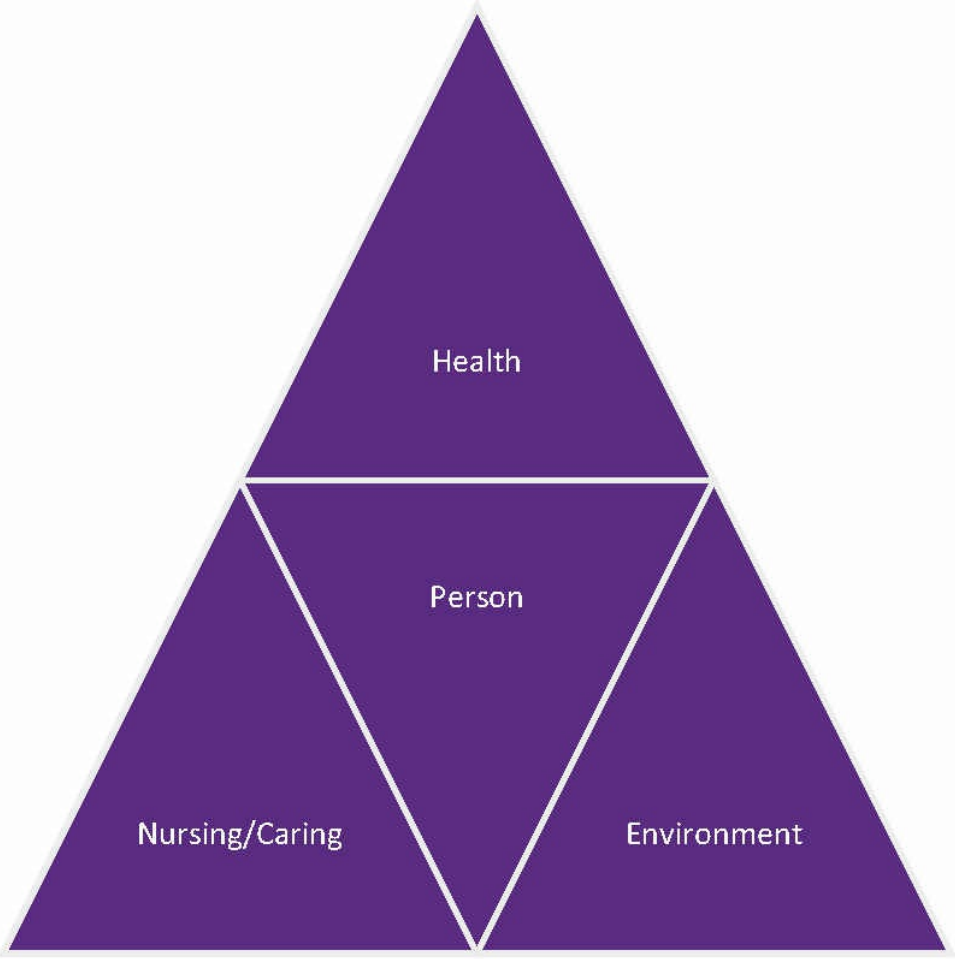
Historical nurse theorists agree that holistic health is a central concept to their profession (Henderson 1966, Leininger 1978, Orem 1985, Rogers 1980, Roy & Andrews 1999). While nursing research and practice have continued to define health in clinical terms, nursing theories incline towards broad holistic definitions of health. This discrepancy was key to distinguishing nursing discourse from that of medicine. In theory, then, the discourse of nursing is separate from that of medicine, but in practice there is evidence of considerable overlap. Both discourses share human wellbeing as the object of concern, and specifically focus on the achievement or maintenance of health. However, nursing science distinguished the pivotal role of a therapeutic relationship enacted through professional caring (Swanson 2013), authenticity (Peplau 1997), respect and compassion (Younas & Maddigan 2019) to create a specific nursing science of caring.

The science of nursing is associated with technical capability and is underpinned by theories, concepts, models and frameworks. Scientific aspects of nursing help us explain how to go about nursing relationships, the importance of the human health experience and contribute to nursing inquiry and evidence-based care.

Terms associated with nursing theory include 'science', 'knowledge', 'philosophy', 'concepts' and 'models'. Science is defined as an integrated body of knowledge focused on specific subject matter as well as the methods and skills necessary to develop such knowledge. The term 'knowledge' refers to what one knows about the subject of the discipline of nursing and includes both facts and beliefs. Facts can be established through science, which is empirically based; that is, it can be replicated through scientific methodologies and is said to provide an observable and measurable outcome. Beliefs, on the other hand, are developed through a philosophical understanding and translate into a conceptual basis of nursing theory. Philosophies of nursing science are

concerned with judgements about components of science. That is to say, 'nursing believes …' statements associated with nursing practice contribute to the philosophy of the discipline and assist nurses to be guided as they attempt to use knowledge.

Nursing science explicitly links nursing practice with people and their health and people's experiences of their health with their physical and social environment (see Fig. 4.1). Scientific theories of nursing define the theoretical focus of the profession and form the basis for nursing knowledge, theories and practice frameworks. An explicit theoretical basis is needed to guide and organise effective nursing care and the science of nursing provides a body of knowledge that describes how nursing practice influences patient outcomes (Callista 2019).



Person: involves not just patients or service users of nursing care, but their families, caregivers and communities and includes the physical person as well as personal meanings.

Nursing/caring: describes the interpersonal, knowledgeable and relational processes between people and nurses that promote health outcomes.

Health: considered from nursing rather than medical orientation, concerns health-related quality of life alongside physical/ social/emotional/spiritual determinants of health and illness.

Environment: describes the physical surroundings of the person, includes significant others to the person as well as the setting where people access health and nursing services.

FIGURE 4.1 The central concepts of nursing Adapted from Roy and Andrews 1999.

Nursing as a practice discipline focuses on working alongside individuals and families in a wide range of contexts and situations. Nurses work with people to assist their transitions through normal life passages such as birth and death, and through experiences of crisis related to health and illness. Nursing also has developed awareness and responses to the contextually mediated choices and socio-political constraints that influence health status. For nursing science to add value, it must inform the human experience of health in ways that allow growing reflection on the quality and applicability of the art of nursing.

HOLLY'S STORY

Holly is in her first year of nursing and today begins her first clinical placement at a residential facility for older people. She is briefed by her clinical lecturer who informs her that she will be working within the hospital wing of the rest home looking after older people who need considerable assistance with their activities of daily living such as showering, dressing, eating and mobility. Holly doesn't have much experience with older people, other than her grandparents and an elderly neighbour. When she arrives at her placement, she is told by her preceptor to go and introduce herself to a resident called Alice and assist her out of bed, have a shower and get dressed, then help her to the dining room for breakfast.

Reflective question

How does Holly know what to do?

ART AND NURSING

In the many definitions that accompany nursing, in addition to the scientific aspect, art has always been mentioned. Since Florence Nightingale introduced nursing as an art, several theorists have emphasised the aesthetic aspect of nursing in their literature. However, many experts believe that the word *art* has been accepted in nursing without deep thought and criticism. Arts in nursing have a complex and multidimensional meaning that is the backbone of many theories presented. The conceptualisation of an art of nursing is underpinned by aesthetic knowing in nursing (Carper 1978).

According to Herholdt-Lomholdt (2019), aesthetic knowing in nursing is made visible through actions, conduct, attitudes and interactions of the nurse in response to others. Through aesthetic knowing, subjective experiences that are termed the *arts of nursing* make it possible to move beyond the limits and circumstances of a particular moment or engagement. This suggests that nursing includes being able to sense the meaning of the moment and to envision what is possible but not yet real through creative processes of engagement, intuition and envisionment. The meaning of the moment stems from the subjective involvement of the self within a situation. The experience of engaging is not dependent on mental structures or cognitive representations or explanations. Instead, the engagement is intuited from the context of human experiences. Intuiting then

directs creative responses to the unique meaning of the moment and creates new possibilities. As aesthetic knowledge is developed, so too is the art/act of nursing. That is to say, nursing actions develop to create unique and deeply meaningful engagement with others that touch the commonality of the human experience (Reed 2019).

The beginning of this chapter indicated nursing's allegiance to humanism and holism. This is a key philosophical assumption that underpins nursing research and practice and illuminates the difference between medicine and nursing as related but intrinsically different applied disciplines. Nurses express the art or acts of their work through aesthetic knowing. Knowledge about processes and experiences of engagement can be expressed through skills involved and shared understanding of behaviour. For example, consoling or comforting someone experiencing loss is a component of nursing behaviour associated with the concept of compassion and how to do this can be learnt. However, such an art of nursing is expressed directly in the engagement, occurs in the moment and becomes part of a shared understanding of the arts and science of caring.

According to Holopainen and colleagues (2019), caring is a humanistic perspective that is an inherent trait of all good people, but care in nursing has a complex meaning. Nurses are required to articulate what it is that they do with people, and these people and their families expect nursing actions to be explained at the outset. Despite this, many nurses operate intuitively, automatically or reactively (McAllister 2012).

Care, humanism and holistic nursing practice

All care delivered by nurses needs to be generated from values. Value-based care is underpinned by respect, genuine concern and unconditional positive regard for people. A value like respect promotes a connection between the nurse and the person and involves the need for self-awareness.

Self-awareness involves deliberately considering one's own values, beliefs and identity. This includes the ability to consider the values and beliefs of others.

Humanism is suggested in nursing as a perspective on life that is centred on concern for human interests, meanings or values and safeguarding the person's dignity. Holistic nursing relates to knowledge that the person is more than the sum of their parts; it is important to recognise the dynamics and connectedness of biological, psychological, social and spiritual aspects of a person to provide care towards healing and wellbeing (Muir-Cochrane et al 2014). While the science of nursing prepares nurses to make choices in regard to what kind of care is possible, it tends to provide prescriptions for nursing care that are rational, rule driven and technically based (Knutsson et al 2015). However, the art of caring exemplifies the nature of nursing work and is not simply about standard approaches but is more about responding relationally to individual needs and responses.

Caring as a human encounter involves many aspects of human experiences. Caring occurs at the interface of interaction between the cared-for and the carer and has become in nursing a moral imperative focused on protection, participation and partnership (Donley 2014). Nurses can develop awareness of the needs of those receiving care and develop enriched professional caring through physical, intellectual and emotional presence.

Reciprocity and negotiation are important aspects of the caring relationship. Caring provides a sense of control and choice for people through sharing of information, helping, teaching and learning. Empathic communication is a key component of caring that includes active listening, touch, eye contact and facial expressions. Communication enables nurses to 'tune into' the values and needs of people and their families with whom they work alongside (Den Hertog & Niessen 2019).

CARING THROUGH ENGAGEMENT

Engagement is the ability of nurses to overcome clinical situations and connect with patients as unique people. The process of engagement is built over time and includes recognising people as social beings with a need to connect and share experiences with others in order to give meaning to their situation and create a working partnership. In any form of engagement with people there are multiple perspectives.

ALICE'S STORY

Back to the first-year nursing student, Holly. Alice is 79 and has been in the older persons' residential facility for six months following a fall she had at home that was caused by having a stroke. Alice has a daughter who is in her 40s and a grandson who is two. Her husband died last year, and she had been living alone at home prior to being discharged from hospital, after the stroke, to the rest home. When Holly enters Alice's room, she says good morning and opens the curtains. Alice tells Holly to 'get out' and shut the curtains.

Reflective question

What reactions are possible at this point for Holly? How might Holly feel and what could she do?

REFLECTION

Think about the scenario involving first-year nursing student, Holly. What does she need to know to 'care' for the older people she is working alongside in her first clinical placement? How would you define your ability to care for people and how do you know how to care?

Read through the perspectives of Alice and Holly, and write your thoughts about how they both might relate to the central concepts of nursing outlined in Fig. 4.1 (on page 61).

ALICE'S STORY

'As I open my eyes I realise it's another day and I feel fed up already. I just want to go home. This bed is uncomfortable and my arm is hurting. I wish they would bring me my tablets so I can get this pain back under control and get going for the day. I'm thirsty but I knocked the glass of water over last night and no one replaced it. I'm tired—it's hard to sleep in here. That woman down the passage has been shouting out all night. Why don't they help her? I'm sick of her barging into my room and taking my things too …'

The needs of a person requiring care are unique as are a nurse's approach to engagement. Whether care begins with a smile or brief introduction, it begins with trying to understand what it might be like from the person's perspective. Through therapeutic engagement, nurses can identify the needs of the person and therefore this is essential to the type and quality of care being delivered.

HOLLY'S STORY

'I head down to Alice's room, the words of the other caregiver ringing in my ears: "She's a real grump, complains and takes forever to get ready in the morning—good luck with that one!" I knock before I enter the room, "Good morning, Alice, my name is Holly, I'm a student nurse and I will be looking after you today." By the time I finish my sentence and pull the curtain, she is already shouting at me to "get out". I take a breath, turn around and smile at Alice, and introduce myself again—she looks at me more closely then apologises and says she thought I was another resident wandering into her room again. She seems relieved to see me and asks if I can get her a drink of water. I get her one and then sit beside her. Her face looks worried and she is lying in an awkward position in the bed. I am about to ask her if she is okay when the RN walks in the room and says sternly, "You had better get a move on, Holly, Alice isn't your only resident that needs showering and breakfast." '

THREATS TO EMPATHY AND COMPASSION

Effective engagement takes place through using nursing sciences such as assessment and observation, while providing effective communication and compassion so that the person has the opportunity to feel understood (the arts of nursing). However, nurses increasingly report that the need to get through the workload in the environment is sometimes conveyed as a bigger priority than individual needs of people (Tierney et al 2019). From a nursing perspective, the need to engage with people is fundamental to building an accurate picture of the person's needs, including the foundation of empathy, trust and confidence.

An idealised view of caring in nursing is sometimes problematic for the profession, particularly when it fails to live up to expectations. Problems of practice can be foregrounded by nurses and conjure up notions of *good* and *bad* nurses (Evans 2010). Nonetheless, the nurse's capacity to choose how they work is entwined by the structures of the organisations in which they work.

'Compassion outrage' is a term coined to represent how recent inquiries into healthcare environments have raised public anxieties about caring practices in nursing. According to Hutchison (2016), the drive to reform health services has been urged on by public scandals about health professionals, including nurses, lacking compassion. She warns, though, 'scandal may obscure the effect of under resourcing in health services and poses a very real threat to the continued support for state-run services' (2016:32). Understanding the contexts in which nurses care, requires a critical awareness of how policies and resourcing affect the ability for nurses to provide compassionate care.

Nursing environments are complex, and modern healthcare institutions including hospitals, residential facilities and community-based practice venues have brought

about changes in the way nurses practise. Evans (2010) argues that efficient flow of patients through health venues has become a priority, so much so that they now resemble industrial assembly lines, which need to keep running regardless of individual circumstances. Nurses have a central role to play in exercising their power to provide an empathic and personal response to the politically driven economic and healthcare reforms we experience in contemporary practice (see Chapter 10).

A critical core professional value of caring is compassion and an ability to respond with humanity and kindness to others' pain, distress, anxiety or needs (Nursing and Midwifery Board of Australia 2008, Nursing Council of New Zealand 2012, Royal College of Nurses 2015). It is also the possession of knowledge of assessed needs and related scientific principles to identify ways in which to develop empathy, to give comfort and relieve suffering.

Empathy is the ability to connect with the life of another person and to accurately perceive their current feelings and their meaning. Empathy begins with putting your own concerns and needs aside and being open to the other person's perspective and experience.

According to Mills and colleagues (2015), compassionate care in nursing is increasingly an international concern. While the literature to date has focused on redressing a compassion and care deficit across the nursing discipline, they suggest that due consideration be given to its relationship to self-care and self-compassion in nurses. Furthermore, a deficit in these compromises nurses' therapeutic use of self in the provision of compassionate care to patients.

Bivins and colleagues (2017) suggest there is a crisis in nursing care. Despite recent international literature highlighting deficits of care in certain nursing environments (Francis 2013), it is short-sighted to view these in isolation. Nurses' wellbeing and quality of care have been shown to be interdependent (Van Woerkom & Meyers 2015); the impacts of occupational stress and burnout (Koy et al 2015) and compassion fatigue (Ledoux 2015) feature alongside workforce turnover and nurse shortages. Many nurses cope by distancing themselves from patients (Mottaghi et al 2019). While this has implications for the therapeutic relationship, of greater concern is the dehumanisation of patients by a profession that promotes humanistic care. The nursing practice environment is a key factor, but within this environment nurses are, themselves, clearly in need of self-compassion and self-care (Mills et al 2015).

Caring competence in nursing

Interpersonal nurse theorist Peplau (1997) coined the phrase 'caring neutrality'. She suggested that nurses are required to develop a level of congruence between what they say and how they act towards the person with whom they work. Compassionate care in nursing includes healthy communication and personal competence so it is useful for nurses to recognise and be careful about how they express their views, language, behaviour and feelings. Being authentic and hopeful are key ingredients for outcomes of the relationships in which we participate as nurses (Younas & Maddigan 2019). Consideration of our own unique capabilities and limitations can assist us to recognise this in others. This includes being able to recognise and deal with conflict with others

and within ourselves (Chan & Sit 2014).

In order for nurses to effectively communicate, they need to develop confidence and the ability to recognise and understand emotions so they can use this awareness to manage their own responses and relationships with others. Emotional competence as a concept was developed within the fields of psychology and social science (Goleman et al 2013) and now features strongly in the nursing literature (Benson et al 2012, Foster et al 2015, Hurley et al 2019, Lelorain et al 2019, McQueen 2004) (see Box 4.2). Many nursing theories emphasise that nurses should be able to develop relationships that include empathy in order to undertake the role of a professional. Moreover, the ability to manage our emotional life, while interpreting the emotional life of other people, is a prerequisite skill for any caring profession. As the students manage their emotions and tune into the needs of others, they become more able to recognise the patient's emotional needs and this enables students to engage patients in effective communication (see Fig. 4.2).

BOX 4.2 Emotional competence in nursing

Emotional competence in nursing is to become self-aware (self-awareness), develop regard for yourself and work on ways to manage your emotional reactions (self-management). Emotional competence includes using that self-management, moving beyond your own needs (relationship-awareness) and working with another person's issues or needs, including recognising and managing conflict (relationship-management) (Wilson & Carryer 2008).

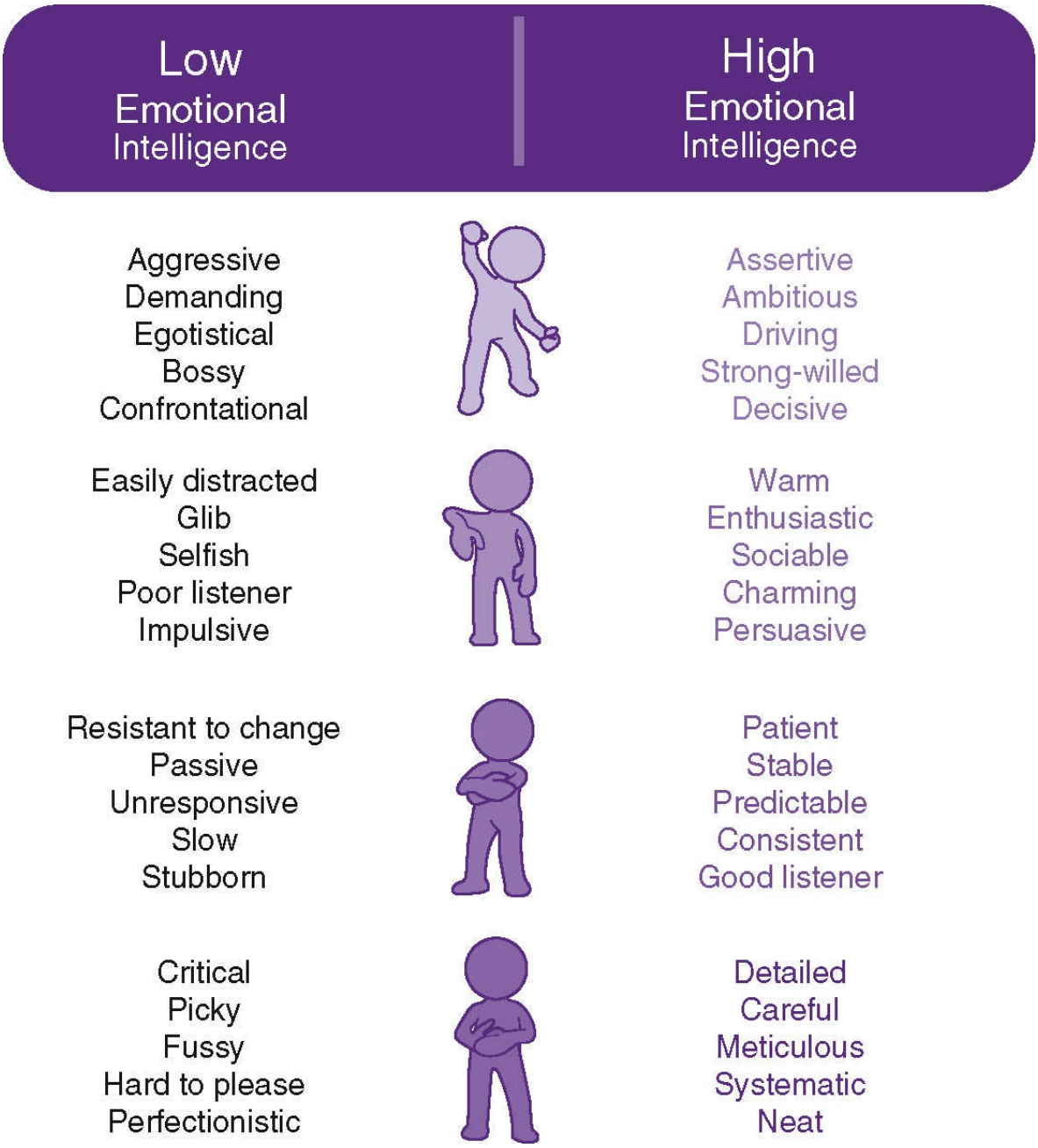


FIGURE 4.2 Emotionally competent characteristics in communication Source: http://www.trans4mind.com/heart/eq.html. Thanks to Peter Shepherd of Trans4mind.com.

Humanistic nursing is an experience lived between human beings, so nurses need to move beyond the technical *doing* of nursing, to become able to experience the feeling and *being* of nursing (Richardson et al 2015). This emotionally competent approach to nursing supports the ability to move beyond the problems of health people may have, to the potential capabilities and relationships people may draw on to maintain their own health and independence. Emotional competence can foster reciprocity within nursing relationships by valuing relationships and supporting each other to create

opportunities to gain confidence in relational being and a sense of trust in our ability to be with people, in ways that are meaningful and authentic. Feeling valued and supporting others extends in nursing to not just people we care for but includes peers and colleagues from various other disciplines.

CONCLUSION

This chapter has introduced a brief history of how science and arts inform the evidence from which nursing provides care and compassion. Nursing knowledge and technical know-how underpin the skills and attitudes nurses enact when working alongside people, their families and the multitude of professional and social services people might use as resources when facing a health crisis. Nurses champion the aim to focus on strengths in people's lives and care about people through attentiveness. They care for others and take responsibility to make certain that needs are met. Through care, nurses provide interventions and emotionally competent interpersonal relationships. Finally, professional, caring nurses are committed to all people in times of uncertainty by providing leadership within health services.

REFLECTIVE QUESTIONS

1. What is on offer for nursing as a profession from you?
2. Compassionate nursing care includes a purposeful commitment to developing knowledge and skills to assess and intervene through nursing actions. These actions bring about positive experiences and change for people while preserving human dignity. How will you develop your ability to communicate caring?
3. Follow this link to learn more about emotional competence by taking a free emotional intelligence self-test: https://www.mindtools.com/pages/article/ei-quiz.htm

Recommended resources

Brief history of New Zealand nursing events. https://healthcentral.nz/nz-nursing-history-100-years-of-nzno/.

Emotional competence self-test. https://trans4mind.com/heart/eq.html.

International Council of Nurses. https://www.icn.ch/nursing-policy/nursing-definitions.

Overview of Australian nursing. https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-nurse.

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CHAPTER 5: BECOMING A CRITICAL THINKER

Steve Parker

KEY WORDS

argument; clinical reasoning; critical thinking; decision making; evaluation; evidence-based; practice; habits of mind; reasoning

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- describe the essential nature and significance of critical thinking in nursing practice;
- explain the basic structure of an argument and apply it to various areas of nursing practice, including clinical reasoning;
- identify resources for further reading and the study of critical thinking.

INTRODUCTION

The focus of this chapter, critical thinking, is an essential skill to have for nursing practice. The Nursing and Midwifery Board of Australia's *Registered Nurse Standards of Practice* (2016) recognise the importance of critical thinking for nurses. Standard 1 describes a registered nurse (RN) as one who 'thinks critically and analyses nursing practice'. This means that:

> *RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.*
>
> *(2016:3)*

Whether we are aware of it or not, all behaviour is based on certain values, assumptions and beliefs. These form the basis for our decisions to act in certain ways. In a professional context such as nursing practice, everything that we think, say or do is the result of a complex web of beliefs, values and assumptions that have formed as a result of our life experiences. As we grow up in our family, attend school, participate in religious communities, associate with friends, watch television, read newspapers and work for various employers, we develop a 'pair of spectacles' through which we understand and interpret the world and all that happens in it. Just as a person who wears glasses eventually becomes unaware that they are even wearing them, so too each of us adjusts to our worldview 'spectacles' until, often, we are completely unaware what values, beliefs and assumptions are influencing us in a specific situation.

If all behaviour is derived from our values, assumptions and beliefs, then our behaviours and decisions in professional practice are also based on these. It follows that poor practice and decision making will occur if our values, assumptions and beliefs are incorrect or unacceptable. The consequences of this are highly significant and potentially improve or undermine patient or client health outcomes—even to the point of sometimes determining whether someone lives or dies. It is because of this link between our beliefs, values and assumptions and practice that critical thinking is essential for high-quality nursing practice. But what is critical thinking, exactly?

REFLECTION

What are the three most important reasons you can think of that demonstrate the importance of critical thinking in nursing practice? Recall any work situations in which critical thinking would have improved the outcomes.

What is critical thinking?

There are a variety of definitions of critical thinking and no general consensus on any one of them (Riddell 2007). Scheffer and Rubenfeld (2000) conducted a very significant

international study to try to arrive at a consensus definition specifically for nursing. The large majority of participants in the study finally agreed that:

> *Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Critical thinkers in nursing practice the cognitive skills of analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge.*

However, there continues to be ongoing discussion of what critical thinking actually is. This situation means we need to be careful about relying on any one definition. Robert H Ennis (2015:32) provides a helpful general definition when he suggests that '[c]ritical thinking is reasonable reflective thinking focused on deciding what to believe or do'.

At the heart of reasonable reflective thinking is the activity of *questioning what is usually taken for granted.* This questioning occurs best when certain *habits of mind* have been developed and a number of *thinking skills* are used to conduct the questioning.

Critical thinking means stopping and reflecting on the reasons for doing things the way they are done or for experiencing things the way they are—focusing on what is frequently taken for granted and evaluating the values, beliefs and assumptions that are held, and asking whether or not what is done and thought is justifiable or not. These characteristics of critical thinking imply a self-consciousness of what, how and why we are thinking, with the intention of improving thinking. Improving thinking is essential, especially in nursing practice which continues to become more complex and which occurs in diverse contexts and under more challenging conditions.

An important aspect of critical thinking is healthy scepticism. This scepticism is necessary because there are many attempts to persuade us to accept various claims. These attempts to persuade also occur in professional contexts. For example, research reports suggest changes to practice; peers argue that their way of acting is the right one; therapists promote various interventions; administrators argue that certain changes need to be made to the workplace; and so on. Often these claims are contradictory, so they cannot all be acceptable.

Practitioners need to sort through all these, often competing, claims. To accept them all without question will, at best, be highly confusing and, at worst, may endanger the lives of others if actions are based on wrong information or conclusions. To adopt an attitude of healthy scepticism means to cautiously listen to or read the claims that others make, carefully evaluate their legitimacy, and not rush to accept a conclusion without careful thought.

The same rigorous thinking needs to be done about our own nursing practice. We make decisions every moment that we assume are of benefit to our patients. Asking questions about the practices we engage in, including what evidence is available to support their efficacy, is essential if our nursing practice is to produce positive outcomes for those for whom we care.

It is possible, of course, to become too pedantic, resulting in inaction, because we are not prepared to accept anything unless it is 100% proven. This is why the scepticism needs to be healthy. There is a limit to what can be known so part of critical thinking is knowing these limits and making the best evaluation under the circumstances.

The characteristics of critical thinking

So, what are the characteristics that a critical thinker will demonstrate? The registered nurse standards of practice referred to above provide us with some useful suggestions. They include, first, the ability to access, use and analyse the best available evidence so that it can be applied to practice and, second, to reflect on one's experience, knowledge, actions, feelings and beliefs so that one can understand how all of these things influence and shape one's practice.

Many more examples of various ways of describing the characteristics of critical thinking could be offered. One way of summarising these is to focus on critical thinking as reasoning. The heart of reasoning is the argument. In what follows, the nature of argument will be described, followed by a survey of the ways in which arguments 'appear' in nursing. Suggestions will then be offered regarding the way in which the principles of critical thinking might be applied in these areas. By doing so, the way in which this approach synthesises the skills of critical thinking will become obvious. Before discussing all of this, though, we need to briefly focus on another dimension of critical thinking mentioned above—habits of mind.

CRITICAL THINKING AND HABITS OF MIND

Like the cognitive skills of critical thinking, the habits of mind associated with critical thinking have been discussed at great length in the literature and there are various lists of them. Costa and Kallick (2008) list 16 habits of mind in their book on the subject: persisting; managing impulsivity; listening with understanding and empathy; thinking flexibly; thinking about thinking; striving for accuracy; questioning and posing problems; applying past knowledge to new situations; thinking and communicating with clarity and precision; gathering data through all senses; creating, imagining, innovating; responding with wonderment and awe; taking responsible risks; finding humour; remaining open to continuous learning; and thinking interdependently.

In essence, habits of mind are the *dispositions* or inclinations of a thinker that influence the way in which a person uses or applies the cognitive skills of critical thinking. For example, the habit of *inquisitiveness,* or curiosity, is fundamental to critical thinking. If a person does not have a disposition towards asking questions and constantly enquiring about what they do not know, they are very unlikely to engage in critical thinking. If a person does not demonstrate a disposition towards *open-mindedness,* they are not likely to examine other points of view that challenge their own. Some of the habits of mind listed by Costa and Kallick (2008) overlap with some of the skills of critical thinking we have already mentioned.

Because these predispositions are habits, they require ongoing practice to improve them. This takes time and *perseverance* (another one of the habits of mind) to practise

them and a commitment on the part of any nurse who wants to improve their critical thinking abilities.

REFLECTION

Do a Google search for *critical thinking* and see if you can find some other definitions. What definition of critical thinking resonates with you?

A HOLISTIC DEFINITION OF CRITICAL THINKING

Paul and Elder (2014) provide a brief definition that synthesises everything we have discussed so far. For them,

> *Critical thinking is … self-directed, self-disciplined, self-monitored, and self-corrective thinking. It requires rigorous standards of excellence and mindful command of their use. It entails effective communication and problem solving abilities and a commitment to overcoming our native egocentrism and sociocentrism.*
>
> *(2014:2)*

This definition is useful because it distils critical thinking down to the idea that an individual will become a critical thinker by applying standards of thinking to elements of thought in order to develop intellectual characteristics that counter negative tendencies we all have towards poor thinking—in other words, an improvement in our thinking. Fig. 5.1 shows a way this could be illustrated.

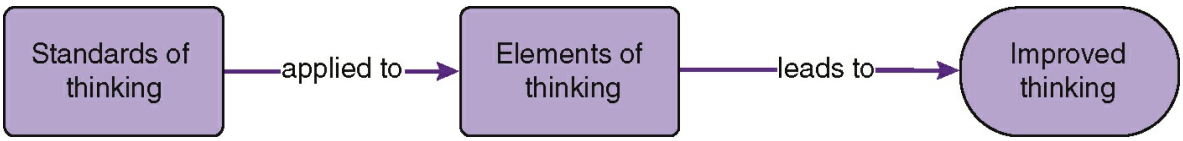

FIGURE 5.1 Critical thinking

There is a lot more detail we could go into about defining critical thinking. However, rather than do that, we are now going to take a look at one aspect of critical thinking that exemplifies what we have covered so far. That aspect is what is called *argument.* We will explore this concept in some depth and explain how it can be applied to a range of areas in nursing practice.

REFLECTION

Think about the characteristics of a critical thinker that have been described here. Which characteristics do you see in yourself? Which characteristics do you think you need to further develop?

What is an argument?

In colloquial language the word ‘argument’ is often used for a shouting match between

two people who are having a disagreement where the participants are very angry, abusive or physically aggressive. There may be shouting, pointing of fingers, threats, crying, name-calling and so on.

However, in critical thinking, the term 'argument' does not apply to these situations. In fact, these situations are the very opposite of critical thinking. In critical thinking, an argument consists of a conclusion and one or more reasons that are intended to support the conclusion. Fig. 5.2 shows the relationship between these parts of an argument. Each reason may or may not have evidence that is intended to support the reason or reasons.

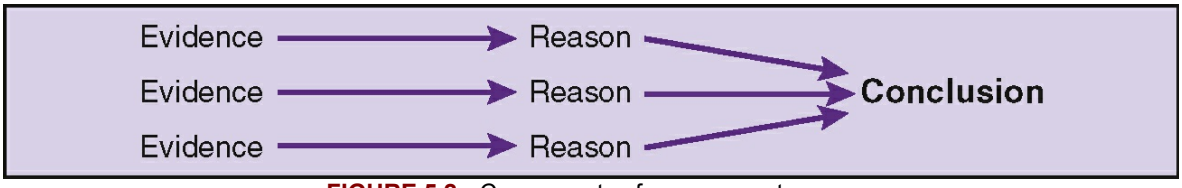

FIGURE 5.2 Components of an argument

Here is an example of an argument:

> *Every person has the right to choose how they live their lives. Therefore, a person has the right to choose to practise life-threatening behaviours if they wish.*

This is an argument because it has a conclusion ('A person has the right to choose to practise life-threatening behaviours if they wish') and a reason intended to support that conclusion ('Every person has the right to choose how they live their lives'). At this stage, we are not concerned whether this is a good argument or not, only with what makes something an argument. If it were desirable, a person presenting this argument could provide some evidence for the first statement by drawing attention, for example, to various statements of human rights, the constitutions of countries or discussions about ethics. Therefore, an argument needs to have the following:

- a conclusion and
- one or more reasons intended to support the conclusion.

WHAT MAKES A SOUND ARGUMENT?

For an argument to be *sound,* three criteria need to be met. First, the reasons need to be acceptable to the person evaluating the argument. Second, the reasons need to be relevant. Third, the reasons need to provide adequate grounds for accepting the conclusion. Let us look at each of these in a little more depth.

When we say the reasons need to be *acceptable,* this means that those who are on the receiving end of the argument must be able to believe the reasons you offer. Sometimes reasons can be evaluated as true or false. However, this is not always possible, so it is often better to think about whether a particular reason is acceptable given what is known.

Of course, if you are offering a reason in support of a conclusion, then it needs to be *relevant.* When something is relevant, it means that it contributes to answering a question, resolving an issue, or solving a problem—or, in the case of an argument, helping us to arrive at a conclusion.

When we talk about *grounds,* we are talking about the weightiness of the reasons in pushing us towards the conclusion. In other words, we are asking whether the reasons we are offering justify us in accepting the conclusion. Sometimes you can have lots of reasons, but they may not always directly support the conclusion.

The following example illustrates these criteria:

Nurses must have a practising certificate to be employed as a nurse.

Sue does not have a practising certificate.

Therefore, Sue is not permitted to be employed as a nurse.

Statements 1 and 2 are both reasons, which are intended to support the conclusion in Statement 3. If this is a sound argument, then the reasons must be relevant and acceptable, and they must provide adequate grounds for accepting the conclusion.

Statement 1 is certainly acceptable. Most countries have a requirement that nurses need to be licensed to practise. Statement 2 is hypothetical, so we will assume that it is true for the sake of the discussion. All the reasons, then, are acceptable. The two reasons are also relevant to the issue under consideration.

The next question is whether these reasons provide adequate grounds for accepting the conclusion. We can test this by asking:

Is it possible to reject the conclusion and still believe the reasons to be true? Or, in other words, even though the reasons are true, is there a legitimate way that we can escape accepting the conclusion?

So, could one believe that Sue could practise and still believe that the two reasons offered are true? In this case, the answer is no. If it is true that a nurse must have a practising certificate to practise, and Sue does not have one, we are 'compelled' to accept the conclusion that Sue cannot practise. This argument, then, is a sound one.

Another example will illustrate a poor argument:

Everyone's hair falls out when undergoing chemotherapy.

Jo is undergoing chemotherapy.

Therefore, Jo's hair will fall out.

First, are the reasons acceptable? Does a person's hair fall out when they are undergoing chemotherapy? Sometimes it does, but not necessarily everyone's. Therefore, this reason is not acceptable because, although some people's hair falls out,

not everyone's does. For the sake of this discussion, the second reason can be accepted (that Jo is undergoing chemotherapy).

Both of the reasons are relevant, and so the final question is whether the reasons offered provide adequate grounds for accepting that Jo's hair will fall out. The answer is no because the first reason was false. Although it might be true that Jo's hair will fall out, it is not possible to predict it because not everyone's hair does when they are undergoing chemotherapy.

To summarise:

- An argument consists of a conclusion, with one or more relevant reasons that are intended to support the conclusion.

- Evidence may or may not be offered to support each reason.

- A sound argument is one in which the reason(s) are acceptable and provide adequate grounds for accepting the conclusion.

There are a few technical terms that need to be remembered in regard to what has been covered so far.

- A *reason* can also be called a premise.

- The question of whether reasons provide grounds for the conclusion is a question of *validity.* In everyday conversation, the word validity often has a broader meaning. In critical thinking, it is used to refer to the logical relationship between the reasons and the conclusion.

- When an argument has reasons that are acceptable and is valid (i.e. the reasons provide adequate grounds for accepting the conclusion), then the argument is said to be *sound.*

It is important to note that an argument can be valid but unsound. For example, the following argument is valid but unsound:

All nurses are female.

Jo is a nurse.

Therefore, Jo is female.

Statement 1 is not true, of course. Some nurses are male. Statement 2 can be assumed to be true. Because statement 1 is false, we already know that this argument is unsound. But is it valid? Yes, it is. If statement 1 were true, the acceptance of statement 3 would be unavoidable. This means that the argument is logically valid, but it is not sound—that

is, it is not a sound argument.

REFLECTION

Arguments appear everywhere—but they are not always easy to spot. See if you can find at least three arguments in different media; for example, social media, news media or a peer-reviewed journal article.

Critical thinking in nursing

Critical thinking, in the sense we are discussing here, means being able to identify the presence of an argument in any form and evaluate it. Once what makes a sound argument, and the questions needed to be asked to evaluate it, are known, it is possible to assess any argument that is encountered. Critical thinking means applying to this task the type of thinking that has the characteristics discussed above.

This basic approach can be applied to many areas within nursing. In the following sections, some examples of these areas will be surveyed, how the basic framework introduced above applies to that area will be discussed and some guidelines for thinking critically about issues in the respective area will be offered. The overlaying of the structure of argument onto the various areas in nursing builds on the work of Mayer and Goodchild (1995) in their discussion of critical thinking in psychology.

CLINICAL PRACTICE

In clinical practice, decisions are constantly being made to act in certain ways for the benefit of clients. These actions can be beneficial or have serious consequences for the health and wellbeing of the people a nurse is working for or with. It is essential that these interventions be considered critically. Fig. 5.3 illustrates the application of the basic argument framework to clinical practice.

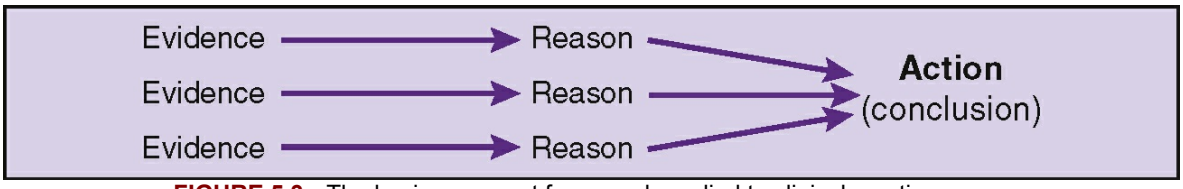

FIGURE 5.3 The basic argument framework applied to clinical practice

As can be seen, very little alteration is necessary. The equivalent of the conclusion is the particular action that has been, or will be, performed. Each of a nurse's actions should be able to be justified by appealing to an appropriate set of reasons. These reasons, in turn, must be based on high-quality evidence.

In the past, many of the actions and interventions of nurses have been based on tradition, folklore or no evidence at all. In recent years, however, the developing professional status of nursing has resulted in more concern about the basis for nursing action. There is a growing and strengthening movement called evidence-based practice, which promotes an attitude of thinking critically about what is done by nurses and

asking on what basis actions can be justified.

The increasing interest of consumers in their own healthcare has also had an effect. People are no longer willing to allow health professionals to make all the decisions for them and are demanding higher-quality care. The increasing incidence of litigation has also motivated a concern for basing nursing action on high-quality evidence.

On an individual level, a nurse should be able to justify any action performed on behalf of a client. The reasons need to be based on solid evidence. The source of this evidence may take many forms, including personal experience, traditions handed down between 'generations' of nurses and what is taught during nurse education. However, on their own, these sources of knowledge are not adequate. A formal process for exploring nursing knowledge is needed, which allows the testing of ideas and the validation of actions and interventions.

The activity of formal research provides this opportunity. Nursing research will be examined below from a critical thinking perspective. First, however, there are a number of questions that can be asked about practice, which will help nurses think critically about it. When reflecting on an action or intervention, ask the following questions:

- What are the reasons for acting or intervening in the way that is planned?
- What evidence is available that supports the reasons for acting in this way?
- Are the reasons relevant to the issue that is being considered?
- Are there other reasons that need to be considered?
- Is there any evidence that raises questions about the manner of acting or intervening?
- Do the reasons provide adequate grounds for acting in the planned way?
- Are there alternative actions or interventions that could be chosen and the reasons still be acceptable in these situations?

CLINICAL REASONING

Clinical reasoning is an essential aspect of the work of nurses and should form the basis of clinical practice as described above. Clinical reasoning is defined as 'the process by which nurses (and other clinicians) collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process' (Levett-Jones 2018). Levett-Jones identifies the following stages of clinical reasoning:

1. Consider the patient situation

2. Collect cues/information

3. Process information

4. Identify problems/issues

5. Establish goals

6. Take action

7. Evaluate outcomes

8. Reflect on process and new learning

We do not have the space to explore these steps in depth. However, it is important to know that this clinical reasoning process is the predominant way of understanding what nurses do in providing high-quality care for patients and/or clients. Let us take a look at how understanding the clinical reasoning process as an argument can be helpful in thinking critically about nursing practice.

The phases of clinical reasoning represented as an argument

The first three phases of the clinical reasoning process can be understood as an argument (remember the technical meaning of the term 'argument'). Fig. 5.4 illustrates this.

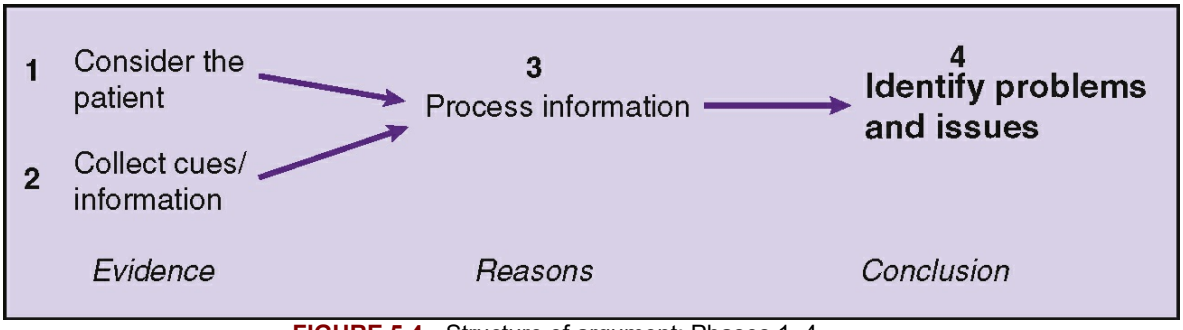

FIGURE 5.4 Structure of argument: Phases 1–4

Identifying problems and issues is the equivalent of the conclusion in an argument. The data that are collected come from observations of the patient, as well as information provided by the client, relatives, friends, history and so on. These raw data need to be processed by the nurse interpreting them and they take on meaning in the context of identifying the problems and issues. Finally, based on the meaning of the data, a conclusion is arrived at in the form of a clear understanding of the problems and issues associated with a particular client.

Of course, the description here is somewhat simplistic. The actual process is much

richer and more complex than this. However, understanding the process of arriving at the problems and issues as an argument leads us to ask questions such as the following:

1. Are the data collected accurate? If not, how reliable are they?

2. Have the data been understood and interpreted correctly?

3. Are the data and their interpretation relevant to the problems and issues that have been identified?

4. Does the interpretation of the data provide adequate grounds for arriving at the identified problems and issues?

5. Are there any other problems and issues that could possibly fit the data that have been collected? Are any of these more consistent with the data?

A similar process applies to the other phases of the clinical reasoning process. Establishing goals, taking action, evaluating outcomes, and reflecting on the overall process all must be justified to support claims of changes such as improvement or deterioration; or preservation of the status quo. For example, does a particular intervention have adequate evidence to justify using it for a particular condition? Or, is a particular evaluation criterion actually relevant to measuring real change in a condition? Figs 5.5 and 5.6 illustrate the structure of argument related to these two phases.

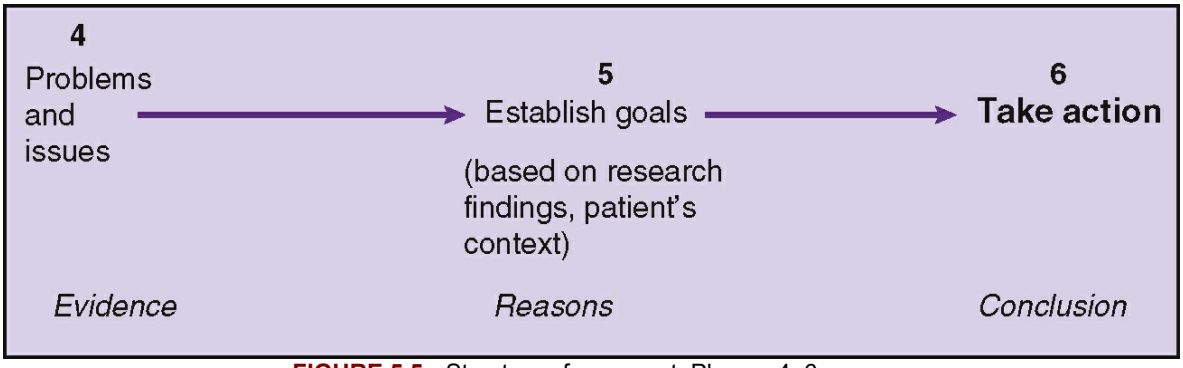

FIGURE 5.5 Structure of argument: Phases 4–6

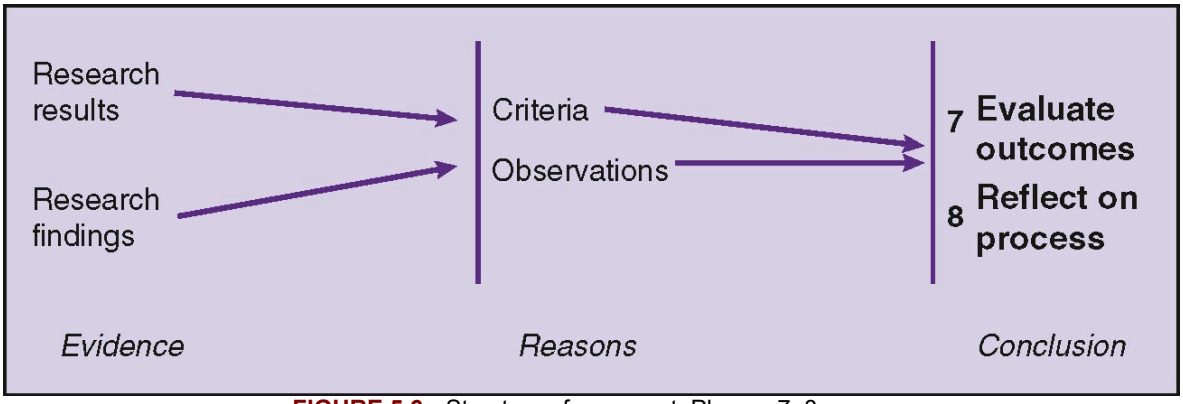

FIGURE 5.6 Structure of argument: Phases 7–8

THINKING CRITICALLY ABOUT RESEARCH

The need for nursing research and the current focus on evidence-based practice has been described above. Nursing research provides the evidence nurses need to evaluate the appropriateness of nursing practice, helps to raise new questions for nurses to explore and provokes new ways of looking at what nurses do.

Nurses may relate to research in three ways. A nurse may be a 'consumer' of research, a researcher, or both. In this discussion, we will be focusing particularly on the role of research consumer.

It has already been argued that nurses must base their practice on high-quality evidence. The results of nursing research form the most significant source of this evidence for nurse practitioners. Nurses must avail themselves of the latest research in their area of practice, and this means that some understanding of the process is important.

Every research project suffers from limitations and flaws of some sort or another. Therefore, nurses cannot take a research report and automatically assume that it provides them with the best guidance for practice. The nurse needs to think critically about research reports. Understanding a research report to be an argument helps the nurse in thinking critically about the conclusions the research report arrives at. Fig. 5.7 illustrates the way in which this works.

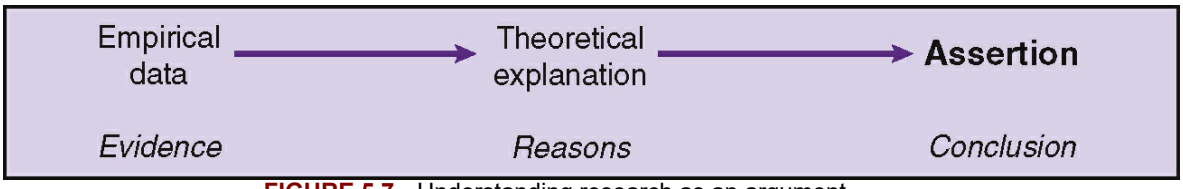

FIGURE 5.7 Understanding research as an argument

Given this understanding, it is possible to formulate a number of questions to help think critically about research:

- What is the assertion that is being made in the research report? What type

of assertion is it? What type of evidence would be needed to be convinced of the truth of the assertion?

- What sort of evidence is offered to support the assertion being made? Is the evidence relevant to the assertion being made? Is adequate information provided to convince the reader that the evidence has been collected rigorously?

- Does the evidence offered provide adequate grounds for accepting the assertion that is being made? Is it possible to think of any other conclusions that could be drawn from the evidence offered? Are these alternative solutions more reasonable than the assertion made in the report?

- Does the theoretical explanation make sense? Are there alternative explanations that make more sense? Does the application of Occam's Razor (roughly this is the principle that the simplest explanation is most likely to be the right one) make any difference to the likelihood of the explanation being correct?

Asking these questions in relation to any research report heightens one's awareness that the conclusions of research are not always correct, nor is the process in arriving at that conclusion automatically sound. This promotes a careful assessment of new nursing practice proposals and consequent higher levels of safety in practice.

Thinking about ethics

Another essential area that nurses need to be aware of is ethics. Thinking ethically means to be able to justify what is done in terms of ethical principles. All behaviour needs to be ethical. Although there are high-profile issues such as euthanasia, abortion and organ transplantation that demand a great deal of attention, they are, perhaps, not the most important issues for nurses.

Issues such as the style of communicating with a patient, the facilitation of the signing of a consent form, communication with other professional colleagues and patients, the management of work rosters, the provision of childcare for employees, the influencing of clients in choosing treatment options—all need to be considered in ethical terms if the individual nurse is to practise with integrity and fulfil his or her obligations to clients.

Most professional bodies have documented codes of ethics and the nursing profession is no different. For example, the ICN *Code of Ethics for Nurses* (which has been adopted by the Nursing and Midwifery Board of Australia from March 1, 2018, contains four elements which are to act as 'a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society. To achieve its purpose the Code must be understood, internalised and used by nurses in all aspects of their work. It must be available to

students and nurses throughout their study and work lives' (International Council of Nurses 2012:4).

Because it is a *guide* and needs to be *applied,* nurses need to develop skills to be able to think through these principles and evaluate various options for practice. Understanding ethical thinking as an argument can help in this task. Fig. 5.8 illustrates the components of an ethical argument. Each of these components will now be examined in relation to critical thinking.

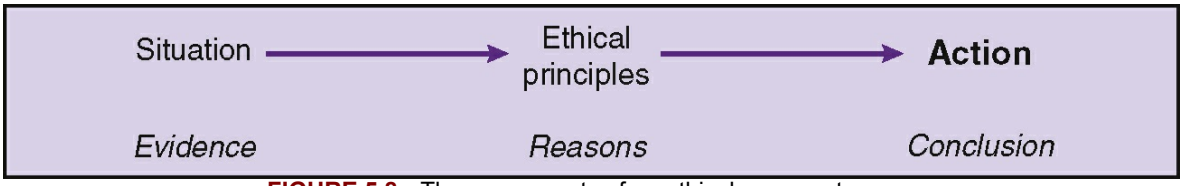

FIGURE 5.8 The components of an ethical argument

THE SITUATION

Ethical thinking is often taught using highly controversial case studies that involve an often-unresolvable dilemma between competing principles. However, a number of false impressions may be gained from this. One possible false impression is that 'the continued use of controversial examples serves to exaggerate the extent to which morality, as distinct from moral theory, is controversial' (Coope 1996:46).

In reality, ethical thinking should pervade all activities, and ethical questions about practice should be continually asked. Ethical thinking should be an everyday activity, which may not always be about problems.

We usually find ourselves in situations where a decision needs to be made about how to act towards another person. These situations continually occur for nurses. For example, a patient might require a sponge in bed. This may not appear to be a situation where ethical thinking needs to take place. But, as this example is explored below, it will be seen that ethical thinking is fundamental to ensuring that the best care is provided.

The first thing to do when thinking ethically is to be aware of as much about the situation as is possible. Too often assumptions are made on the basis of past experience; but every person is different and has unique needs.

THE PRINCIPLES

Everyone has a system of principles (values) that guide their lives and how they act. Some of these will be conscious; others may be unconscious. In healthcare, four principles have been identified as an essential starting point for ethical thinking. They are:

1. Autonomy: the right a person has to direct their own life and make their own decisions.

2. Beneficence: the responsibility of actively doing good.

3. Non-maleficence: the responsibility to actively avoid doing harm.

4. Justice: the responsibility to be fair in the way we treat others.

After gaining knowledge of the situation, the next step is to ask which of the principles (values) are relevant to consider in the particular situation in which the nurse finds themselves. In the example of the person who needs to be washed in bed, the issue of autonomy is clearly relevant. How is autonomy to be ensured in this particular situation? How will the patient be empowered to make their own decisions about their hygiene and the way they wish to maintain it?

The principle of beneficence is also relevant. The whole reason for instituting the patient washing in bed is because it is believed it is good to promote hygiene. It is possible, however, that beneficence may spill over into a denial of the person's autonomy. When this happens, nurses are acting paternalistically—doing what they think is best for the patient—even if the patient does not agree with the nurse. Paternalism needs to be rigorously justified because it overrides a person's fundamental right to autonomy.

Many examples can be found of situations where paternalism occurs: imposing medication on a psychotic individual; or legally enforcing a blood transfusion for a child of a Jehovah's Witness parent. On many occasions paternalistic attitudes prevail without adequate ethical justification.

Depending on the specific circumstances, the other ethical principles (justice and non-maleficence) may also need to be considered.

ACTION

Once the situation is understood and the implications of the relevant ethical principles have been thought through, it is necessary to make a decision about how to act. Often this will not be easy. Sometimes, ethical principles conflict with each other (such as when beneficence and autonomy conflict). Nurses do not live and practise in an ideal world, and so it is necessary to be satisfied with the best decision that can be made under the circumstances. The point is not that perfect decisions have to be made; that is never possible. It is rather that whatever decisions are made and whatever actions are performed, they have been carefully thought through and can be justified by appeal to accepted ethical principles.

The ethics of critical thinking

Often, when people learn the tools of critical thinking, they become highly critical of others. It is important that critical thinking be viewed primarily as a set of tools applied to one's own thinking. When evaluating the ideas of others, critical thinking skills are used to decide whether an idea is acceptable or should be rejected. One of the most important distinctions to remember is that between an idea and the person who

presents the idea. Usually, but not always, it is irrelevant who the other person is. When critical thinking skills undermine or attack other people, then the purpose of critical thinking is lost.

The critical thinker always needs to think critically within the framework of well-developed interpersonal relationship skills. Critical thinking skills are not weapons to be wielded to cut another person down to size. They are tools of personal growth, which allow one to travel through an often-confusing landscape and keep one's bearings, while providing the best possible quality care for those to whom one is responsible and accountable.

REFLECTION

Which of the above areas of nursing practice are most relevant to you in your own work? How will you begin to practise critical thinking skills in that area?

Developing critical thinking skills

There is no magical solution to actually developing critical thinking skills. An awareness of what critical thinking is and where it can be applied is an appropriate start. Like anything, it requires continual practice. Ultimately, it is about developing a conscious attitude of reflection during daily and professional life. We have discussed the need for habits of mind that are needed to continually apply and improve in critical thinking. It takes practice—and more practice. As Halpern (2014) says:

> *No one can become a better thinker just by reading a book … An essential component of critical thinking is developing the attitude or disposition of a critical thinker. Good thinkers are motivated and willing to exert the conscious effort needed to work in a planful manner, to check for accuracy, to gather information, and to persist when the solution is not obvious or requires several steps.*
>
> *(2014:18)*

Although it is hard work to develop new skills in critical thinking, the time and energy are well worth the rewards that come with the ability to think clearly.

You may also find using some software useful in helping you think critically. There are quite a few software packages available that can help visualise arguments and aid in the process of analysis. One of the best of these is Rationale, which allows you to create diagrams of arguments and your evaluation. Fig. 5.9 shows a diagram, produced by Rationale, of the argument about hair loss following chemotherapy described above. You can access information about this software from https://www.rationaleonline.com/

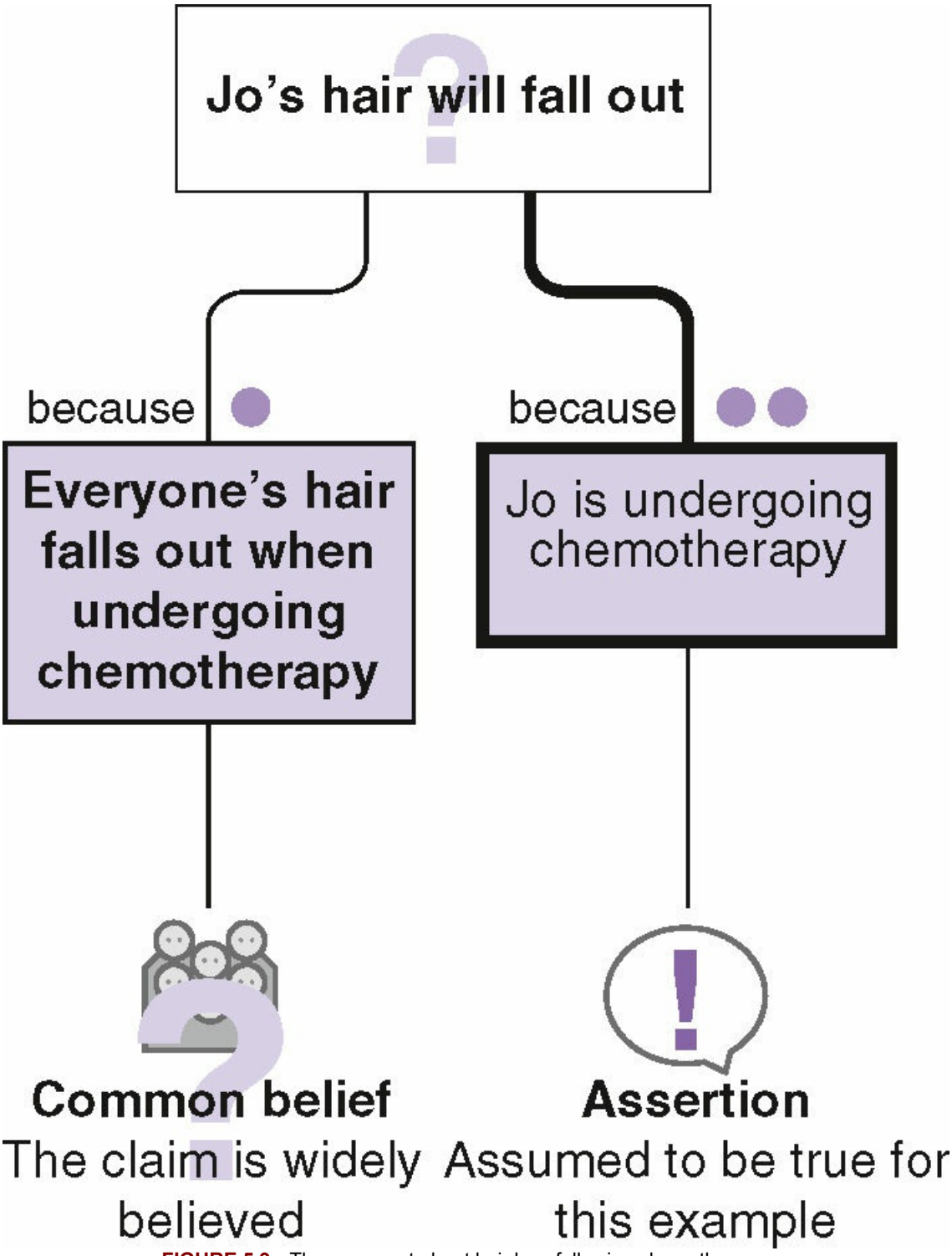

FIGURE 5.9 The argument about hair loss following chemotherapy

There are also an increasing number of apps available for iOS (Apple) and Android devices. Have a go at searching for *critical thinking* in the app stores for your respective device.

REFLECTION

What resources are you going to follow up to learn more about critical thinking and how you can apply it in nursing practice?

CONCLUSION

Critical thinking is a vital skill to have as a nurse. Nurses are engaged in providing care to people who have a right to high-quality professional conduct and health services. Nurses have a responsibility to make sure that their actions are based on rigorous evidence and can be justified with acceptable reasons. Although developing the skills to think critically may at times be difficult and demanding, thinking critically provides a greater level of confidence and satisfaction as nurses interact with colleagues, and it promotes high-quality, safe practice.

REFLECTIVE QUESTIONS

1. How has your understanding of thinking changed as a result of reading this chapter?
2. What areas of your professional life would benefit from applying the principles of critical thinking to them?
3. What will you do now to further develop your skill in critical thinking?

Recommended readings

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CHAPTER 6: REFLECTIVE PRACTICE: WHAT, WHY AND HOW

Kim Usher and Zachary Byfield

KEY WORDS

reflection; reflective; practice; critical thinking; critical incident; analysis; journalling

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand the importance and benefits of reflection to nursing, a practice-based discipline;
- have insight into the nature of reflection and the ideas of its leading theorists;
- appreciate the link between reflection and professional nursing practice;
- understand the strategies that assist with reflection;
- have insight into the legal and ethical issues surrounding reflection.

INTRODUCTION

Nursing is a dynamic profession that must be able to respond to the changing needs of society. Advances in healthcare knowledge and reduced government spending has led to a reduction in hospital beds, shorter hospital stays, and more rapid patient turnovers. As a result, healthcare professionals are spending much more of their time dealing with complex individuals who require specialised care (Mitchell et al 2013). In order to function in these complex environments, practitioners are required to constantly 'refresh and update their knowledge and skills, and frame and solve complex patient and healthcare problems' (Mann et al 2009:595–596). Reflecting can cause feelings of concern or confusion, but it also offers us an opportunity to reconceptualise our profession by making it more responsive and reflective of the needs of the individual and society. The role of the nurse is influenced by cultural, social, economic, historical and political constraints that all influence the ways in which nurses approach and react to certain situations (Taylor 2010). It is a given that society expects nurses to practise safely and to undertake what is necessary to keep up to date. Reflection helps us to self-correct where the notion of continuous improvement becomes habitual to our practice (Usher et al 2019).

As a consequence of the constantly changing healthcare arena, today's nursing graduates must not only be clinically competent practitioners, but also need to be adept at *critical thinking* in order to understand the complexities of the world and the rapidly changing practice arena, even though this can itself be challenging (Johns 2017, Mann et al 2009). Critical thinking, or the practice of questioning, is necessary so that practitioners integrate relevant information from various sources, examine assumptions and identify relationships and patterns (Thompson & Thompson 2018). *Reflective practice* and critical thinking are often used interchangeably, but, while not identical, there is a reflexive relationship. After all, as Lumby (2000:338) explains, '… to adopt a critical approach to the world, it is necessary to reflect on the world and one's experiences in it'.

This chapter introduces you to the *what*, *why* and *how* of reflection. The first section explains *why* reflection is a useful strategy for undergraduate nursing students, as well as registered nurses. The next section of the chapter addresses the *what* of reflective practice, including an overview of the definitions of reflection. Finally, the chapter closes with discussion around tools and techniques which may assist the reader in understanding *how* they can go about engaging in reflection and reflective practice.

Why be reflective?

Every workplace presents a complex environment to the new recruit. It is often difficult to understand and appears to abound with multiple decisions, each coupled to a host of different ways in which the desired outcomes could be achieved. Nursing is no different. When you first enter a nursing context, perhaps during your first clinical placement, you will be confronted by discrepancies, such as those between 'ideal' and

'real' practice. You may also experience or witness difficult interpersonal relationships. It is important that these unpleasant situations do not distract you from your nursing goals or from seeking to provide the best possible care. Although systematic reflection may at first seem difficult to undertake when you are working in a demanding clinical situation, reflection will help you to recognise and set aside the emotional content and enable you to learn from otherwise negative experiences. Reflection can take on an even more important role when you find yourself faced with difficult working conditions and environments (Usher et al 2019). Proposed as a way to make meaning out of complex situations (Mann et al 2009), reflection will help you identify alternative ways you could react in the future, hopefully resulting in more positive outcomes. Importantly, reflection helps to ensure that our practice does not become so routine that our actions begin to contradict our values (Thompson & Thompson 2018).

Johns (2006) explains how reflection offers a way to bring to the surface the contradictions between what you intend to achieve in a situation and how you actually practise. In other words, being faced with contradiction opens the possibility for change and offers the practitioner the opportunity to achieve desired practice. One of the outcomes of reflection is thus a process of continuous monitoring and improvement of practice. It assists us to avoid taking situations at face value but rather to move beyond the taken-for-granted assumptions that may be informed by prejudice and discriminatory ideas (Thompson & Thompson 2018).

Regulatory authorities in Australia have embraced the need for practitioners who are reflective, and require that all nurses engage in some form of reflective activity. This is explicit in the Nursing and Midwifery Board of Australia's (NMBA's) *Registered Nurse Standards for Practice* (NMBA 2016). They comprise seven interlocking standards, the most relevant here being the first, which concerns critical thinking and analysis. One component of this standard states that the registered nurse 'develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice' (NMBA 2016:6). The *National Competency Standards for the Midwife* (NMBA 2018c) also has reflective and ethical practice embedded throughout its seven domains. Furthermore, the *Code of Professional Conduct for Midwives* (NMBA 2018a) and the *Code of Conduct for Nurses* (NMBA 2018b) also require that they practise reflectively and ethically.

In addition, the Nursing Council of New Zealand (NCNZ) has also incorporated reflection as a key competency for registered nurses. In the New Zealand registered nurse competencies, reflection is a component of domain one, which focuses upon the professional responsibilities of the registered nurse (NCNZ 2012). Similar to the NMBA, the NCNZ also has information about codes of conduct and scope of practice for nurses. Further information about these competencies is available from the following websites:

- Nursing and Midwifery Board of Australia: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

- Nursing Council of New Zealand:

http://www.nursingcouncil.org.nz/Nurses

As a result, all pre-registration nursing programs of study must ensure graduates have been provided with the opportunity to develop the skill of reflection. In other words, it is a requirement of your nursing education that you exit the program of study with the ability to reflect.

What is reflection or reflective practice?

Reflection comes from the Latin verb *reflectere*, which means to bend or turn backwards. This infers that reflection is a process of going back over something after it has already occurred. The reflection might include recalling thoughts and memories, in cognitive acts such as thinking or contemplation, or as a way of making sense of the situation so that necessary changes may be identified or made (Hickson 2019, Taylor 2010). We all reflect on what goes on around us to some extent. If you think about it, we do not generally just walk around in the world without noticing things or thinking about what has happened and how it has impacted on us. Similarly, we all reflect at some level on our practice, but it may only involve thinking about what happened rather than theorising about what happened and looking for ways to improve it in the future.

Thus, the type of reflection to be discussed in this chapter is actually a much more purposeful activity that leads to action that is better informed than that which occurred before the reflection took place (Thompson & Thompson 2018). Rolfe and colleagues (2001) argue that not all knowledge for practice comes from textbooks, research journals and lectures or other classroom activities. Rather, they claim that, in addition to what they call scientific knowledge, practitioners actually 'pick up' practical knowledge from their everyday experience, and reflection is the process of *theorising* about that knowledge. This may be seen in the process of communication. While your degree of study may contain some theoretical and practical content on the process of communication, you will already have some familiarity with the process of communicating with another individual. Reflection therefore provides the practitioner with access to the processes by which he or she makes clinical judgements, which can then be used to justify actions to others or pass on expertise to less experienced colleagues.

Taylor (2010) sees it as necessary to alert clinicians to the intricacies of nursing practice and the knowledge embedded in it, but Johns (2010) claims that being a reflective practitioner is more than just noticing things by chance in a situation; it also involves a deep sensitivity to what is happening around us, and as such '… take[s] time to develop through constant attention and care' (Johns 2010:191). It is also important not to assume that improved skill in reflective thinking equals learning, which in turn equals improved nursing practice. Learning from reflection is not something that happens automatically. For reflection to be most useful to the learner it is essential that it is performed critically and in a structured manner (Usher et al 2019).

Much of the contemporary emphasis on reflective practice in nursing can be attributed to the work of the American educationalist Donald Schön (1983, 1987). Even

though he was not the first to write about it, he actually coined the term 'reflective practice', and has been very influential in the way nursing has embraced the notion. Schön (1983) argued that reflection is a strategy whereby professionals become aware of their implicit knowledge base. While he did not attempt to define reflection or reflective practice, he advocated two distinct types of reflection: *reflection-on-action* and *reflection-in-action.* The former, reflection-*on*-action, occurs after the event or action, and involves recalling and analysing details with the aim of reviewing practice.

Reflection-*in*-action occurs simultaneously or at the same time as practice. That is, reflection-*in*-action is said to occur when the practitioner engages in practice and makes adjustments as a result of relevant feedback. Reflection-*in*-action is a more advanced form of reflection and leads to more advanced practice. It is a process whereby the nurse is constantly testing theories and hypotheses in a cyclical process while simultaneously engaged in practice, which can also be referred to as a 'nursing praxis' (Rolfe et al 2001).

There is an additional step in the reflective process, that of *pre-reflection* where individuals engage in reflection in anticipation of events. Pre-reflection involves the learner becoming aware of what they bring to the event and what they want from it (the personal), the constraints and opportunities the event provides (the context) and how they may acquire what they need from the event (the learning strategies). In fact, in many cases anticipation of challenging events is thought to stimulate reflection (Boud et al 1985, Mann et al 2009).

The roots of reflective practice

The ancient Greek philosopher Plato declared that the unreflective life was a life not worth living. Plato was drawing attention to the view that reflection is a distinctively human activity and without it we would be no more than unthinking automatons, our lives governed by our biological instincts and forever subject to those forces, human and natural, exerting power over us. Plato saw reflection, in other words, as vital to our identity as human beings and to our having a mind of our own, and thus to our personal freedom. We are free, he concluded, only to the extent that we are reflective beings.

REFLECTION

Consider your personal experience with reflection. Perhaps beginning your nursing degree might be a good place to start.

Did you engage in any pre-reflection? Did you think about what this would mean to you and how it would impact on your life, your opportunity for a professional career or whether or how you would work with people in the clinical setting?

Did you engage in any reflection on action? Have you thought about an event or experience where you have identified you would like to improve your practice? You may have done this individually or as a group, or even formally as an assessable item in your studies.

Did you engage in any reflection in action? Have you encountered a difficult event or

situation where you have been required to think through the issues and how you might address them as they are occurring? You may have done this during an experience in the clinical setting.

This idea resurfaced and drove the huge change of thinking that occurred in seventeenth- and eighteenth-century Europe, which became known as the Enlightenment. Enlightenment argued that human beings are free to think and decide for themselves rather than simply accept the prevailing norms, largely imposed by those in power and notably by the Christian churches. Today we just accept this as natural and probably do not think twice about it, but in those days, it was a radical and rather dangerous claim.

This history reminds us of several important principles concerning reflection. First, reflection is not an artificial technique that is being imposed by regulatory authorities or universities; rather, it is the refinement of a natural process that is part of being human, and which needs to be nurtured and encouraged. Second, we should always reflect upon, and if necessary, challenge prevailing ways of thinking and acting, even if it occasionally means being unpopular or thought foolish. When it involves 'big issues', this may be hard to do, but reflection and action working together (i.e. 'praxis') is the impetus for change, and ultimately for improvement. This applies in all arenas of human activity, including your local healthcare setting.

Although there are many ways of conceiving reflective processes, even within the same discipline, reflection as we refer to it here is not simply thinking, but rather thinking deeply, systematically, logically and deliberately. Political theorists have emphasised the role of reflection in challenging the status quo, and it plays an important part in the teachings of some political radicals and revolutionaries. Educationalists have emphasised the role of reflection in learning and problem solving and have explored how reflection is related to experience. For example, Rolfe and Gardner (2006) referred to the observation by Dewey that 'we learn by doing and realising what came of what we did', and this realising is the result of reflection.

Reflection also played an important part in the development of psychology as a discipline during the nineteenth century, in the form of 'introspection'—that is, reflection focused upon oneself. Until the rise of scientific psychology in the 1880s, introspection was the primary source of data for the elucidation of human psychology. An especially important figure, who brings the political and educational aspects together, is the Brazilian Marxist Paulo Freire. His work is widely cited as the basis for the development of reflective processes in nursing, although nurses have mostly shied away from acknowledging the political revolutionary aspects of his work. Freire's concept of reflection was developed as part of a strategy for educating and politicising the impoverished and largely illiterate peasants of Brazil, and has an explicit emancipatory intent. The key idea, which makes it 'emancipatory', is that reflection and action should work together, in order to generate new, enlightened and empowering ways of thinking and behaving.

This is an important way for you to think about reflection because, as a nurse, you will work in complex systems where you may feel powerless and unable to express

your concerns, similar to those individuals discussed above. In order to create a sense of control and of having a worthwhile part to play, you can begin by engaging in reflective processes, and out of these should arise constructive courses of action.

The benefits of reflection

Some of the benefits derived from reflective processes have already been noted, but let us now discuss these in more detail. It is essential that action and reflection work together, and for this reason action is seen as an important outcome of the reflective process (Johns 2017). However, 'action' can take many forms. For example, when you reflect upon your practice world and become sensitive to its inadequacies and injustices, you are most likely to want to do something about them, especially as you consider them in relation to individuals' rights. In contrast, action might involve improving your own clinical skills; your reflections having alerted you to shortcomings in your attitudes or skills, and you take action to bring them to a higher standard.

Thus, reflection has the effect of 'educating the emotions'. Reflective processes should be mutually encouraged, and there is an educative element as you help others by recognising and responding to their needs and sensitivities, as well as your own; reflective processes also help you come to terms with the uncertainty of clinical practice and with its inevitable injustices and inadequacies. Clinical practice is never perfect; it is always constrained by resource shortages and by the failings of the system and those who work in it. It is part of the human condition that we cannot do everything right all the time, and that things sometimes go wrong. Reflective processes enable us to face up to this reality, but at the same time challenge us to overcome the obstacles and aspire to the best possible standards of practice. They contribute to our development as thinkers, practitioners, and as people.

Another benefit of reflection is that it can help you elucidate the theory–practice relationship. Critical social theory insists that this relationship is 'reflexive'; in other words, theory feeds into your practice and practice informs your theory. This supports the suggestion by nurse theorists Walker and Avant (2013) that reflective processes can be used to help develop clinical practice by helping you to recognise, evaluate and refine your personal nursing theories. Indeed, reflection can be used to help elucidate and develop your beliefs about nursing and clinical practice. Since critical social theory is closely tied to these conceptions of reflection, it is widely argued that any theory of nursing developed in this way should be consistent with critical social theory, and many nursing scholars have attempted to show how this can work. This link has become more difficult to sustain, however, as critical social theory has been the subject of criticism in light of alternative ways of thinking about social structures and processes, including 'post-structuralism' and 'postmodernism'.

Another positive outcome of reflection, which follows on from its role in the 'education of the emotions' noted above, is that it encourages us to be sensitive to the needs of individuals from marginalised and vulnerable populations. We become more sensitive to the suffering, courage and determination of people who are faced with serious illness and to the problems faced by those who are oppressed, such as mentally disordered and intellectually disabled people and people who belong to ethnic and

religious minorities. This increased sensitivity impels you towards greater engagement with such people, and a willingness to become involved in their problems. Not only are you aiming to improve your clinical performance, but you will also develop your ability to support and advocate. You are not only motivated to question inadequate practices, but also to generate possible strategies for improvement. Even though it may be challenging, you will find that you cannot do otherwise, and you will enjoy increased levels of job satisfaction because this heightened level of engagement is intrinsically rewarding.

We might add that these benefits accrue not just in the context of your work, but also in your life generally. The big claim being made here is that because reflection educates your emotions and impels you to action, it helps to make you a better person, not just a better nurse. Let us now turn to consider the 'how' of reflection.

Strategies for reflection

Many strategies can be used for reflection, including writing (e.g. journalling and critical incident analysis), photography, drawing and other forms of creative expression.

WRITING

Reflective writing has long been advocated as a technique to aid reflection (Jasper 2015, Johns 2010). Writing for the purpose of reflection differs from other forms of writing in that it is undertaken primarily for the purpose of learning and to assist us to develop a deeper understanding of the subject of our reflection. Van Manen (1990) suggests that in reflective writing we come to know and understand the way in which we know what we know. By writing and rewriting we can come to understand something in greater depth, in ways not previously open to us and in new or more intimate ways. For example, Boyd's three phases of reflective learning—preparatory, experiential and processing—can be undertaken in your nursing practice, and provide actual examples of nurses' written reflections (Boud et al 1985).

Journalling and *critical incident analysis* are two well-known types of reflective writing, but clinical supervision, poetry, letter, story- and group-writing activities are also examples of reflective writing.

Journalling

Journalling is one of the more common forms of reflective writing and is often recommended as a strategy for the development of reflective practice (Johns 2010). By the term 'journal' we mean what is commonly referred to as a diary or log. Writing a journal involves the writing of accounts of practice experiences after they occur and allows the writer to take ownership of the content—for example, using the first person and writing about themselves.

However, journal writing offers the practitioner more than the opportunity to recount an experience; it provides an opportunity to return to the experience in its written form and then theorise about the experience from which conclusions are drawn. This type of reflective writing provides for many returns for analysis and the writer can add, delete

or change entries as often as they wish. As a result, it becomes an ongoing critique of the practitioner's thoughts about an experience as well as their overall practice. Journals have also been described as cathartic because they offer an opportunity to 'work through' problems or difficult situations (Davies & Sharp 2000). Some students find starting a reflective journal a difficult task, but you should remember that there is no right or wrong way to do it. However, it is important to remember that journalling for reflection is different to the process of journalling for personal use. There is a need to put value upon the process of journalling if it is used for reflection, ensuring that you are thinking critically during and about the process. Taylor (2010) offers a number of hints that may also be helpful: be spontaneous; express yourself freely; remain open to ideas; choose a time to suit you; be prepared personally; and choose a reflective method. It is also important to avoid the use of abbreviations, and resist the temptation to censor your writing, as this is more likely to assist with the exposure of the 'isms' we hold as an individual. Box 6.1 lists some journalling techniques, which may be useful for all reflective practitioners.

BOX 6.1 Journalling techniques

Write a short biography to begin.
Select a quiet environment where you will not be interrupted.
Write vividly and as close to the event as possible.
Include your initial thoughts, but leave space where you can add comments at a later time.
Where possible, make use of diagrams, illustrations, photographs and drawings to aid your memory.
Make use of a book and use one side for writing and leave the other for later reflections.

Owens et al (1997).

A further strategy that may also be helpful is the notion of a *critical friend.* Sharing with others opens reflective journal entries to a different perspective. The other person may offer alternative actions that could have been taken or might challenge you to think more deeply about a particular issue (Baguley & Brown 2009). It is important that the critical friend is someone you trust, as they will be reading your entries and discussing them with you. The role of a critical friend is to support and guide you in your reflection, while posing questions and offering alternatives in a non-judgemental way (Taylor 2010).

Ethical and legal issues related to journalling

One aspect of journalling that became a problem in the early 1990s, and is still discussed in the contemporary setting, concerns its ethical and legal status. In short, these concerns were:

- whether journalling required the consent of institutions and individuals to whom it referred

- whether journalling was appropriately conducted in work time or in the clinician's own time
- who owned the journals, and who had a right of access to them, and
- what status the journals had in law; for example whether they could be used as evidence in the court room.

With the formal recognition that registered nurses are required to be 'reflective practitioners', it is now widely accepted that journalling can be considered part of their professional practice. However, intellectual property is a vexed issue in law, and there does not appear to be any precedent set in either Australian or New Zealand law as to the obligations of clinicians in relation to journals, but there does appear to be general acceptance that they belong to their authors, and that employers therefore normally have no right of access. Despite, or perhaps because of these issues, you should ensure that your reflective journals conform to the usual ethical standards that apply in healthcare situations—namely, that they are securely stored and accessible only to authorised individuals, that you use pseudonyms when referring to particular individuals, and that they are strictly for your private professional use. Existing privacy provisions in Australia and New Zealand require that no information is gathered from an individual beyond what is required for the appropriate management of their health problem, and so you should not obtain additional information simply for the purposes of your journal.

Like all documents, journals may be ordered to be submitted as evidence in courts of law. Although this is extremely unlikely, and most of what appears in a journal may only have the status of 'hearsay evidence', it is wise to bear this possibility in mind. Another principle you should adopt, therefore, is that your journal should always refer to your colleagues and individuals in your care in a professional and respectful manner, even though it may express criticism. Your journal is, after all, not simply a vehicle for catharsis or unrestricted emotional expression. Rather, your reflective journal is the professional documentation of your deeply and carefully considered thoughts.

You may prefer to maintain a 'live' e-journal rather than a 'paper and pencil' document, and to engage in reflective writing online. In either case, you must be careful to observe all the legal, professional and ethical restrictions that apply. These refer principally to matters of privacy and accuracy as they concern colleagues, patients and others, and you should obtain relevant guidance or policy documents from your employer, education provider and professional organisation.

Critical incident analysis

A critical incident is usually an event that is remembered as important to an individual or one that is provided to a learner for the purpose of reflection. The notion of a critical incident is considered problematic by some (Griffin 2003, Thompson & Thompson 2018) who suggest that the term is negative because it brings to mind something unfortunate or life-threatening.

Critical incidents, however, should be thought of as events that are meaningful or significant in some way; they need not necessarily be large or major occurrences, and they can be negative or positive experiences (Davies & Sharp 2000). Critical incident analysis is thought to lead to:

> *… a deeper and more profound level of reflection because it goes beyond detailed description of an event that attracted attention, to analysis of and reflection on the meaning of the event.*
>
> *(GRIFFIN 2003:208)*

Rees (2013) found that engagement with reflective practices helped nursing students to understand and better manage the distressing emotional challenges of their work. Participants in the study also reported that reflection helped them understand what it meant to them personally to be a nurse. Box 6.2 provides a framework for a critical incident analysis.

BOX 6.2 Framework for critical incident analysis

1. Give a concise description of the incident (which relates to the learning outcomes).

2. Outline the rationale for choice of incident and its significance and relevance to you.

3. Identify pertinent issues related to the incident.

4. Reflect on and analyse the key issues focusing on: your own involvement; feelings and decision making; the involvement and role of others; identification of any dilemmas or ethical elements; and the rationale for action, drawing on relevant theory evaluation of the situation and the implications for practice and personal learning.

5. Conclusion.

Davies and Sharp (2000:67–68.)

PHOTOGRAPHY, DRAWING AND OTHER FORMS OF CREATIVE EXPRESSION

Taylor (2010) describes how reflection can be facilitated by creative expression. She explains that it is unclear whether the awareness of the creative expression precedes or follows the reflection, but that it occurs sufficiently to include it as a way of reflective thinking. Some have been inspired to draw or write poetically as a result of events they

have experienced, while others have used art forms, such as photography, drawing, painting or music in an attempt to express their reactions. Rolfe and colleagues (2001) explain that these techniques are described as creative because they involve using the imagination to transform experience away from the more accepted ways of analysis to the use of metaphor as a way of creating insight and facilitating learning. Their value is nicely illustrated in a study by Coleman and Willis (2015): participants reported positive benefits from the use of poetry in reflective writing and preferred it to formal methods of reflective writing because it freed them up to express their feelings.

SELF-AWARENESS AND CLINICAL SUPERVISION

In essence, self-awareness is the foundation skill upon which reflective practice is based. It offers individuals the opportunity to see themselves in certain situations and to observe how they affected the situation and the situation affected them. In fact, this is what differentiates reflection from other types of mental activity such as logical thinking or problem solving (Boud et al 1985). Reflection is also a very personal experience, as it opens the self up to scrutiny (Johns 2010, 2017). As a result, reflection can be disconcerting to the individual, as taken-for-granted competence and ways of coping are exposed as inadequate.

Self-awareness is also an essential skill for professional monitoring. As a professional you are required to be aware of yourself, and the influence you have on the person and the healthcare context. Consequently, constant and vigilant self-monitoring is an important skill that every nurse needs to develop. Registered nurses need to come to an understanding of any preconceptions and attitudes, and identify how these impact on their practice. An awareness of your own frailties and susceptibilities is crucial to maintaining high standards of practice.

Many nurses find it difficult to adequately care for their own psychological and physical wellbeing, and yet are under pressure from their work and their domestic lives. For example, it is important to consider whether you are going to work tired and distracted; whether you are overanxious, depressed or angry; whether you are going to work with a hangover. Many nurses find that the stress of their lives leads them to overuse medications, smoke heavily or resort to illicit drugs (Happell et al 2013). The reflective practitioner is aware of these tendencies and will take remedial action, seeking appropriate advice and support.

A similar argument applies to any tendency that may ultimately lead to professional misconduct, including inappropriate preconceptions and other prejudiced attitudes. A reflective practitioner becomes aware of these possibilities, takes action and thus maintains high standards of practice. This self-monitoring role leads us almost seamlessly into the issue of clinical supervision.

Reflective processes have been linked by many authors to the process of clinical supervision, and it is true that an effective clinical supervisor will lead the student through reflective processes to assist in developing reflective nursing practice. Severinsson (2001) described how clinical supervision in nursing can be based on a ‘reflective practitioner model’, citing the work of Schön and Johns, both authors we have mentioned in this chapter. Severinsson (2001) sees reflective processes as integral

to the analysis and understanding of the theory–practice relationship, which is one of the goals of the supervisee, and the consequent development of 'know-how'. She also sees reflection as essential to self-awareness, emotional education and the development of 'know-what'. Supervision should be 'centred on enhancing the practitioner's ability to "reflect-in-action" ' (Severinsson 2001:40)—that is, on the care being provided. She explains that:

> *Clinical supervision demands reflection on what care is being provided. Reflection can result in a better understanding of oneself. There is a difference between concentrating on the dissatisfaction within oneself and striving not to repeat what caused it (e.g. feelings of guilt). It is important to find answers to questions such as: Why did I make this mistake? Why did I fail to observe factors of relevance in caring for this patient? A deeper insight into patient needs may thereby be developed.*
>
> *(SEVERINSSON 2001:43)*

When you think about the above statement, it is not difficult to see how reflection could become a powerful tool in the supervisory process, and lead to real improvements in healthcare that individuals can receive.

Problems, criticisms and responses

Despite their endorsement by regulatory authorities and encouragement by educators, the use of reflective processes in nursing is not without critics. The empirical evidence for their effectiveness in increasing critical thinking, promoting learning and improving practice, remains weak (Mann et al 2009), but the reasons for supporting them are strong:

- Although little research has been conducted on its value to nursing, the concept of reflective practice is supported by empirical research conducted and elaborated over many years, notably in education, and the accumulated evidence as to its value in a variety of disciplines (e.g. science, social work, medicine, law, education) cannot be ignored.

- The research results, although limited, are favourable, and there is no evidence that clinicians taking time to engage in critical reflection has any detrimental effects.

- There are strong *a priori* (logical) arguments in its favour, such as the argument that a problem is unlikely to be acted upon unless it is recognised as a problem, and that learning entails reflection, and not merely experience or the absorption of facts.

- Reflective processes acknowledge the value of the experiences and beliefs of all members of a discipline in contributing to its knowledge base and practice development; the alternative is that the views of a privileged group are allowed to dominate.

- Reflective processes happen naturally, and one cannot simply stop them without denying an integral part of one's personal identity; the alternative is to be robotic.

Finally, for the sake of balance, we should add that there are also a number of theoretical arguments that can be levelled at reflective processes in nursing. Cotton (2001) brought attention to some of these, notably:

- despite its championship by many nursing authorities, reflection remains ill-defined and elusive

- reflection is a strategy for scrutinising private thoughts, a form of policing or surveillance by oneself on behalf of others

- reflection only masquerades as radical; in reality it is aimed at imposing a standardised way of thinking and acting, and

- not enough attention is paid to the negative effects of reflection and the problems that arise in trying to be a reflective practitioner.

These are important issues that need to be considered by those who champion reflection, but none of them are necessarily fatal to that cause. The alternative consideration to these criticisms is that:

- the meaning of words is a matter of convention, and agreement takes time to emerge

- self-scrutiny is a positive feature of professional life; indeed 'profession' is often characterised by such self-regulation

- the aim is to open up the practitioner's mind to possibilities, not to impose rules, and reflective practitioners are therefore more likely to be creative, to challenge the status quo and to be independent thinkers, and

- the problems of reflective practice may have been underestimated, but they are increasingly acknowledged; in any case, this means only that we need to be better at reflective processes, not that they should be abandoned.

As a reflective practitioner you should consider carefully, and reflect upon, the claims made in this chapter, and come to a reasoned and practical personal arrangement for your own development. To help you do this, consider the questions below, and undertake some further reading on the subject.

CONCLUSION

In summary, reflection is a useful learning and professional development strategy that helps the practitioner to monitor their practice, recognise the link between practice and theory, remain in touch with their values, develop awareness of their impact on their work and on relationships with others and remain in touch with the needs of the vulnerable in society. Reflective practice, while still considered to be a developing area by some scholars, is now considered of sufficient importance to be mandated by the regulatory authorities that oversee the practice of nurses and midwives. There are many strategies to enhance reflective practice such as writing, journalling, critical incident analysis, creative techniques and clinical supervision. Most importantly, continue to reflect on your practice and develop reflection as a routine part of your day.

REFLECTIVE QUESTIONS

1. How would you use pre-reflection to prepare yourself for the challenge of clinical practice?
2. Write a paragraph about how you will use reflective processes during your clinical practice. In the paragraph address the following:

a. the technique you think would be best suited to you and why

b. whether a framework would help you, and

c. the benefits you might receive.

3. How will you use reflective processes to enhance your self-awareness and ensure you practise at the highest possible standard?
4. Why is it important for you as a reflective practitioner to understand the theoretical background of reflection?

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CHAPTER 7: RESEARCH IN NURSING

Elizabeth Halcomb

KEY WORDS

methodology; methods; paradigm; qualitative; quantitative; research

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand evidence-based clinical practice and the role of research in informing clinical practice;
- appreciate the range of approaches to research in nursing;
- describe the basic research processes in nursing and start to critically review research.

INTRODUCTION

This chapter introduces the basic concepts of research in nursing and highlights the important role of research in developing nursing knowledge. It also discusses how research can enhance health outcomes for individuals, their families and communities and develop the nursing profession. For many years, nursing research has been viewed with negativity and suspicion by clinical nurses and nursing students. Research has been seen as a 'waste of time' or an academic task disconnected from clinical practice. This chapter will dispel some of these myths and highlight how research can enrich nursing practice, policy, education and the workforce. It will also discuss how nurses can engage in research both within their practice career and as a distinct career option.

Research in nursing is not a new phenomenon. Florence Nightingale was an active researcher in the early nineteenth century. While perhaps best known for her work around sanitation, Nightingale was a passionate statistician, a pioneer of survey instruments and graphical data presentation for systematic data collection and using evidence to guide health and social policy (Mussatto & Kessel 2015). Nightingale identified key research issues, such as differential mortality between population sub-groups, the impact of care provided by trained and untrained nurses and childbirth mortality (McDonald 2015). Despite these early advances, nursing research did not progress substantially before the 1940s. Indeed, government support for nursing research in the United States wasn't initiated until the 1950s (D'Antonio 1997) and it was not until 1963 that the first UK government-funded position for nursing research was established (Mulhall 1995). Finally, in 1972, the Briggs report recommended that UK nursing should develop an evidence base upon which to base clinical practice.

In Australia and New Zealand, nursing was not established as an academic discipline with a significant presence in universities until the 1980s. Prior to this, nurses were trained in an apprenticeship model within the hospital setting. Given this relatively recent transition, the numbers of doctorally prepared nurses who can provide leadership and disciplinary scholarship continues to grow across Australasia. The most recent published data shows that in 2008, some 468 candidates were enrolled in a research doctorate through an Australian University School of Nursing (Council of Australian Postgraduate Associations 2010).

Contemporary nursing has clearly moved beyond the historical handmaiden role to become accepted as a profession in its own right. One of the key characteristics of a profession is that it has 'special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level' (Australian Council of Professions 2018). The importance of developing the nursing body of knowledge has been recognised by various professional organisations. The International Council of Nursing states that: 'Nursing research, both qualitative and quantitative, is critical for quality, cost-effective health care' (International Council of Nurses 1997:2). Nursing research, however, extends beyond work to optimise care delivery and promote quality health outcomes, to include a range of issues affecting nurses and nursing.

Within Australia, the importance of research for all nurses is evidenced by the inclusion of relevant statements within the standards for practice for all levels of nurse (AHPRA Nursing and Midwifery Board of Australia 2018). These standards define how nurses are expected to identify relevant research, apply evidence-based practice principles in clinical practice, evaluate the quality of evidence and support/contribute to nursing and health research.

What is research?

Research is a rigorous process of inquiry designed to answer questions about phenomena of concern within an academic discipline or profession. It is defined as 'systematic inquiry that uses disciplined methods to answer questions or solve problems' (Polit & Beck 2017:3). Developing and conducting an original study, where data is collected to answer a research question, is called 'primary research'. The collation and/or synthesis of existing research, such as occurs in literature, integrated or systematic reviews, is considered to be 'secondary research'.

Nurses are concerned with a range of important issues that can be the foci of research. Of prime importance is improving the quality of nursing practice, patient care and the health outcomes of individuals, families and communities. However, nurses are also concerned with a range of related issues such as establishing and evaluating best clinical practice, improving nurse education, monitoring and exploring nursing workforce issues, and understanding concepts around nursing education and management. Nursing research is necessarily diverse to address these various problems (Halcomb & Hickman 2015). So while some studies are designed to directly inform clinical practice by describing a clinical activity, or comparing various ways of performing an intervention, other studies may shed light on individuals, family/community or nurses' experiences of phenomena that are poorly understood, such as a particular disease process, or specific concepts such as hope or suffering.

In the same way that nursing education and management are underpinned by adult learning principles, pedagogy and management theory, research too is underpinned by a series of principles and well-established but diverse traditions. In a chapter such as this, it is possible to present only a broad overview to familiarise the reader with the language of research and highlight its key underpinnings. To develop detailed knowledge and understanding of nursing research in general or any one of the research traditions, methodologies and/or methods, will require further study and reading from a variety of sources as well as intellectual engagement with the materials.

Nurses' involvement in research

The degree of involvement a nurse has in research will vary between individuals; however, all nurses will use research in their career. Crookes and Davies (2004) describe the levels of research use and understanding using the '4As of research' model, namely:

1. **Awareness** of and access to the research literature

2. **Appreciation** or the ability to understand and critique the language of research

3. **Application** of research findings to local practice settings

4. **Ability** to conduct original (primary) research independently or in a team.

During their undergraduate preparation, nursing students will gain an awareness of the research literature and develop key skills in appreciation of the language of research and research critique. Unfortunately, there is a tendency amongst nursing students to undervalue these skills, compared with more clinically focused learning (Halcomb et al 2018). However, this grounding in understanding the language of research and critiquing research is vital to support the application of research into clinical practice. Using research is a powerful tool to ensure that our clinical practice, education, management and workforce activities are effective both in terms of being a responsible allocation of finite resources and optimising the health outcomes for individual patients, their families and communities. To ensure that nurses can appropriately critically appraise research it is vital that they have a good knowledge of research terminology (Table 7.1) and the research process as well as an understanding of research design considerations.

TABLE 7.1

Research terminology

TERM	DEFINITION
Paradigm	A way of viewing the world, an overarching framework of values, beliefs and assumptions.
Methodology	The approach to the research process taken by the researcher (e.g. phenomenology, grounded theory, randomised controlled trial).
Design	The overall plan for collecting data within a specific study.
Methods	The specific strategies used to collect data within a study (e.g. interviews, surveys, observation).

The first three As all seek to cultivate and nurture nurses to be empowered to ensure that their practice is based on the best available evidence. However, the final A, ability, refers to nurses taking on active roles in conducting research. As a dynamic profession with our own body of knowledge, nurses need to take responsibility for designing and conducting high-quality research within our discipline. Such research is necessary to:

- test commonly held knowledge or assumptions
- increase understanding
- stimulate self-action/study

- develop best practice
- explain behaviours
- test predictions, and
- assist in the development of new nursing knowledge.

Generally, there are two kinds of roles that nurses involved in undertaking research can play. First, research nurses/research assistants play an important role in supporting the practical aspects of conducting a research study, such as participant recruitment, data collection, data entry, project administration, data analysis and reporting. These individuals are often employed for a specific project or may have ongoing employment across projects within a research centre or team. These nurses may have undertaken some additional training or education in specific aspects of data collection, project management or analysis techniques. Second, nurse researchers are leaders or members of the research team who are responsible for the conceptualisation, design and planning of the study, as well as managing the overall project, data analysis and dissemination of study findings. Nurse researchers are usually either undergoing or have completed a Bachelor of Nursing (Honours) course or a Higher Research Degree, such as a Master of Philosophy or Doctor of Philosophy, which has prepared them to undertake independent research (Geraghty & Oliver 2018, Halcomb et al 2018).

In addition to being involved in conducting or leading nursing research, nurses with research skills have an important contribution to make to interdisciplinary or multidisciplinary research teams. Beyond providing assistance in recruitment and data collection, nurses can provide a unique insight into the conceptualisation and design of interdisciplinary or multidisciplinary research by bringing a nursing perspective to the table.

REFLECTION

1. In your clinical experience what involvement have you seen nurses have with research?

2. Was this level of involvement appropriate? Why/Why not?

Nursing research approaches

Research traditions can be investigated in relation to their philosophical underpinnings. In the course of your reading of research you will encounter a number of essentially different paradigms. A research paradigm is an overarching framework that is based on values, beliefs and assumptions (Corry et al 2019, Hewitt-Taylor 2011). This framework contains theory about the nature of reality and guidelines for the methods to be used in carrying out research within the paradigm (Corry et al 2019). In addition, the ideas

within the paradigm have implications for the type of knowledge being sought in a study, the way in which the study will be carried out and the way in which outcomes from the work will be used. The nature of the specific research *problem* and scope of the research question determines the most appropriate research paradigm to use in the given situation.

The two major paradigms in nursing research are Positivism and Naturalism/Interpretivism (Kelly et al 2018). While a detailed discussion of the underpinnings of these paradigms is beyond the scope of this chapter, some of the key differences are summarised in Table 7.2. The third key paradigm is Pragmatism, which involves a combination of approaches to best design research that answers complex research questions (Halcomb & Hickman 2015, Nowell 2015).

TABLE 7.2

Differentiating paradigms

POSITIVISTIC PARADIGM (QUANTITATIVE RESEARCH)	NATURALISTIC PARADIGM (QUALITATIVE RESEARCH)
• Reductionist	• Holistic
• Focus is specific	• Focus broad and complex
• Objective	• Subjective
• Deductive reasoning	• Inductive reasoning
• Cause and effect	• Meaning, discovery
• Tests theory	• Develops theory
• Control	• Shared interpretation
• Instruments	• Communication, observation
• Numbers	• Words
• Generalisability	• Uniqueness

QUANTITATIVE RESEARCH

Quantitative research includes studies that seek to objectively measure a concept or phenomenon of interest (e.g. blood pressure, pain level or quality-of-life score). The quantitative research paradigm is also called positivist, reductionist or empirical. It is referred to as reductionist as it reduces the concept under investigation to a numerical value. Quantitative research uses deductive reasoning, which means that the thinking leads from a known principle to an unknown, and is used to either test a particular research hypothesis or objectively describe a concept or occurrence.

Quantitative research encompasses a range of research designs and associated methods; the most common designs used in nursing research are outlined in Table 7.3. Selection of an appropriate design is undertaken based on the specific research question being posed.

TABLE 7.3

Common quantitative research designs

DESIGN	PURPOSE
Descriptive study	Examines characteristics of a single sample; clarifies concepts; generates questions about potential relationships between variables (e.g. case study, cross-sectional analysis).
Correlation study	Examines (describes, predicts or tests) relationships between two or more variables, but does not infer a cause-and-effect relationship.
Quasi-experimental study	Tests a cause-and-effect relationship, but without either a control group or randomisation (e.g. case control, intervention only).
Experimental study (randomised controlled trial)	Tests a cause-and-effect relationship using randomisation of subjects to groups, manipulation of an intervention and a control group.

QUALITATIVE RESEARCH

Qualitative research is a broad term encompassing a range of research drawn from subjective human experiences. These data are derived from either narrative, observational or non-numerical sources in naturalistic settings. Qualitative research often involves close, sustained contact between the researcher and participant(s) (Holloway & Galvin 2017). This approach uses inductive reasoning, whereby theory is developed out of the participants' experiences. The term 'qualitative research' spans a range of methodological approaches and research designs (Table 7.4). This field of research has its origins in the humanities disciplines, such as philosophy, anthropology, history and sociology (Liamputtong 2016). The qualitative researcher approaches research with a different set of values and beliefs from the quantitative researcher. In qualitative research, value is placed on individual subjectivity, multiple truths are accommodated and individuals who participate in the study are regarded as active participants and partners in the research (Liamputtong 2016).

TABLE 7.4

Common qualitative methodologies

DESIGN	DEFINITION
Phenomenology	Exploration of the lived experience of the phenomenon of interest (Jobin & Turale 2019, Picton et al 2017, Rettie & Emiliussen 2018).
Ethnography	Derived from anthropology, ethnography is a study of cultures and sub-cultures (Baillie 2019, Molloy et al 2017).
Grounded theory	Develops theoretical explanations for an occurrence and generates hypotheses for future research (McCann & Polacsek 2019, Polacsek et al 2018).
Case study	An in-depth examination of a 'case' or specific environment (Heale & Twycross 2018).
Descriptive qualitative	Explores a phenomenon of interest from a distinctly human perspective (Colorafi & Evans 2016, Willis et al 2016).
Participatory action research	Researchers work with participants in cycles of Planning, Acting, Observing and Reflecting to achieve change (Casey et al 2018, Cusack et al 2018).
Feminist research	Researcher attempts to see the world from the vantage point of specific groups of women to reduce their oppression (Fraser & MacDougall 2017, Klages et al 2019).

Qualitative research can either be interpretative or critical. Interpretative methods are richly descriptive in nature (Holloway & Galvin 2017). They seek to explain, describe, generate meaning and make sense of the phenomenon of interest. These methods allow exploration of a range of human experiences that are of interest to nursing from the perspective of individuals, their family and community and/or nurses themselves. Interpretative methodologies include phenomenology, grounded theory, ethnography and descriptive qualitative research.

In contrast, critical qualitative research involves researchers working collaboratively with participants to effect change in the status quo (Cannella & Lincoln 2015). It is the explicit intent of critical qualitative research for social or political change to occur as a result of the research. Critical methodologies include participatory action research and feminist research.

MIXED METHODS RESEARCH

Mixed methods research is most often associated with the pragmatic paradigm, whereby the choice of methods is made based on the most appropriate means to answer the specific research questions (Halcomb & Baille 2018). A mixed methods study combines both qualitative and quantitative methods of data collection in a single study (Halcomb & Baille 2018). Such broad data collection provides multiple perspectives of the topic of interest, thus allowing a deeper exploration than would be revealed by either qualitative or quantitative methods alone (Halcomb & Hickman 2015). Just because you could collect both qualitative and quantitative data within a single study doesn't mean that you should (Halcomb 2018, Younas et al 2019). Mixed method designs have significant implications for resources required, project duration and skills needed and, therefore, should only be used when the deeper insight assists in answering the research question more adequately (Halcomb & Baille 2018, Younas et al 2019).

Mixed methods research studies can broadly be categorised into either sequential or concurrent designs (Halcomb & Baille 2018) (Table 7.5). In sequential studies one method of data collection follows the other, with the second method usually either taking data from or building on the first method. Concurrent studies, on the other hand, collect qualitative and quantitative data simultaneously. The choice of a sequential versus a concurrent design must consider both the purpose of the research and any time constraints on the project (Halcomb & Baille 2018).

TABLE 7.5

Common mixed methods research designs

DESIGN	PURPOSE
Sequential explanatory	Quantitative data are collected first and then qualitative data are collected to explain the quantitative findings.
Sequential exploratory	Quantitative data are collected to build on qualitative findings.

Convergent parallel	Quantitative and qualitative data are collected concurrently to obtain different but complementary data to answer a single research question.
Embedded or nested	Quantitative data collection within a qualitative study or qualitative data collection within a quantitative study. The embedded dataset answers a complementary but discrete research question.

THE RESEARCH PROCESS

Regardless of the paradigm, methodological approach or design, the research process generally follows a series of basic systematic steps (Box 7.1). Following the identification of a problem, the researcher will need to know what is already known about the problem (via a critical literature review) and identify what is not known (the research gap). Conducting a literature review involves the development and conduct of a robust search strategy and the appropriate critical synthesis of identified literature. Health librarians are well placed to assist in identifying appropriate search terms and suitable databases to be included in the search. In terms of the critical literature synthesis, various review methods have been described in the literature (Aveyard & Bradbury-Jones 2019, Aveyard et al 2016, Halcomb & Fernandez 2015, Whittemore & Knafl 2005). A suitable review method should be selected based on the topic, resources and purpose of the review.

BOX 7.1 Overview of the research process

1. Identify research problem
2. Review literature
3. Develop a research question
4. Design study proposal
5. Recruit participants
6. Collect data
7. Analyse data
8. Report and disseminate findings
9. Translate findings to practice

Once the literature review is completed, the researcher will next formulate the research question that they will seek to answer through their study. The specific research question will determine which research design and method will most

effectively answer that question. Once the project proposal has been developed and the study has received approval from an ethics committee (where human participants are involved), participants are recruited and data is collected. Data collection and analysis may occur concurrently or sequentially depending on the type of study. The specific analysis strategies will be determined by the kind of data collected. Once the data has been analysed, the researcher(s) need to communicate their findings. While this step in the research process often receives limited attention, dissemination of the findings is vital if others are to learn from the research. Findings should be made available to researchers, clinicians and end-users. This may require a range of dissemination strategies, including peer-reviewed papers, conference presentations, stakeholder meetings and policy briefs. Arguably, the most difficult step occurs last, which is for the results of the findings to be incorporated into usual care (translation). To truly achieve translation of findings into practice requires commitment from the researcher(s) and sustained engagement with stakeholders.

EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP) has become a commonly used term in nursing and healthcare circles. However, there are a lot of misconceptions about EBP and what it means in clinical practice. The notion of EBP was first introduced into medicine by Archie Cochrane in the 1970s (Grove 2019). Since this time, it has been translated across the healthcare system.

Sackett and colleagues (1996) define EBP as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinician expertise with the best available evidence from systematic research' (71). Clearly, from this definition, EBP can only be achieved via the combination of the best available clinical evidence, individual clinician expertise to apply this evidence to the individual situation and preferences of the individual, family and/or community around resource allocation and care choices. A major criticism of EBP is that it is 'cookbook' practice that seeks to reduce clinicians to following guidelines to make decisions about service provision. However, this criticism often comes from those who forget to incorporate clinical expertise into the EBP equation. As a clinician, it is your clinical expertise that decides whether a particular piece of research evidence applies to the individual patient and if it does, how this evidence should be integrated into clinical decision making.

CRITICAL APPRAISAL

Determining best available evidence requires nurses to be able to effectively critically evaluate research. To assist in comparing various types of research evidence, the Australian National Health and Medical Research Council provides a hierarchy of evidence to guide decision making (see Table 7.6). This hierarchy identifies that the evidence obtained from more rigorous research designs should be weighted more strongly than the evidence from less rigorous designs. However, critical appraisal of research needs to go beyond this and critically interrogate the conduct of the specific research project. Today there are many established tools to facilitate a structured

critique of research. In particular, organisations such as the Joanna Briggs Institute (www.joannabriggs.org) and the Cochrane Collaboration (www.cochrane.org) provide clear guidance around specific strategies for critical appraisal. These organisations also provide training courses and online modules to develop critical appraisal skills. Regardless of which critical appraisal tool is used, good critique of research is a skill that requires knowledge of the research process and practice to develop and maintain.

TABLE 7.6

The National Health and Medical Research Council (NHMRC) evidence hierarchy

LEVEL OF EVIDENCE	TYPE OF STUDY
I	A systematic review of level II studies
II	A randomised controlled trial
III-1	A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: • non-randomised, experimental trial • cohort study • case-control study • interrupted time series with a control group
III-3	A comparative study without concurrent controls: • historical control study • two or more single arm study • interrupted time series without a parallel control group
IV	Case series with either post-test or pre-test/post-test outcomes Descriptive study

NHMRC 2009 (CC BY 3.0 Australia).

USING EVIDENCE IN PRACTICE

There are three steps to using research evidence in clinical practice. The first, evidence generation, is commonly referred to as research. This step involves discovering the knowledge through primary research and disseminating it to others. The second step is evidence translation, which involves converting the knowledge gained from research into a format accessible by clinicians and able to be applied to clinical practice (Polit & Beck 2017). This includes activities such as best practice information sheets and clinical practice guidelines. Finally, evidence utilisation involves applying the knowledge gained from research into the clinical setting (Polit & Beck 2017). Within this step there may be some evaluation of the effectiveness of the new knowledge or around the implementation of changes in practice.

REFLECTION

Identify a clinical practice guideline relevant to your clinical practice. What features of this guideline document help you to understand the evidence behind the recommendations?

Where do we find research?

Research can be found in many places. High-quality research is largely published in

academic peer-reviewed journals; however, the grey literature provides important research findings in the form of research reports, project and literature summaries and resources. The growth of social media and the internet has led to a concomitant growth in electronic dissemination of research findings (Dardas et al 2019). Such strategies can now rapidly disseminate research to a large geographically dispersed audience. These various dissemination channels also have the advantage of using different levels of language and pitch which can increase the reach of the findings to the broad group of stakeholders including lay people, policy makers and managers.

PEER-REVIEWED JOURNALS

Peer-reviewed journals are an important vehicle for the dissemination of research findings and discussion about research methodology and methods within the profession. The term 'peer-reviewed' means that each paper that is published has been subjected to a review process involving peer reviewers and editorial oversight to ensure the quality of the work. Peer reviewers are individuals with expertise, knowledge and skills in the topic area. Criteria that must be met before a paper is accepted for publication in a peer-reviewed journal vary; however, all editors ensure that a standard of excellence in regard to scientific merit, the literary standard of the paper and the relevance of the paper in terms of its potential to contribute to knowledge development is maintained. Although the reader can have a degree of confidence in the quality of the work published in the peer-reviewed literature, they should still critically appraise the research described in a peer-reviewed paper before applying findings into practice. While Australia and New Zealand have their own nursing research journals such as *Collegian* (http://www.collegianjournal.com), *Contemporary Nurse* (https://www.tandfonline.com/toc/rcnj20/current) and *Kai Tiaki Nursing Research* (http://www.nzno.org.nz/resources/library/research_journal), the internationalisation of publishing means that peer-reviewed papers from Australasia appear in a range of international journals.

Predatory journals

In recent years there has been a growth in 'predatory journals' in nursing and many other disciplines (Darbyshire 2018, Watson 2019). These journals make money by charging authors fees to publish their papers. In the digital era where papers are often sourced online, these publications can appear deceptively similar to legitimate journals, particularly where journal names have very similar wording. However, care should be taken to avoid these sources as there is no peer-review process and papers are included regardless of their quality.

GREY LITERATURE

The term 'grey literature' is used to refer to documents produced by organisations, such as government, academics and businesses outside of commercial publishers (Bonato 2018). Grey literature is so named because of the uncertain quality of the document (Bonato 2018). These documents have not been reviewed for either accuracy or quality and, with the growth of the internet, can be widely disseminated with limited oversight

of the standard or accuracy of the content. While high-quality grey literature can be found on the websites of reputable organisations (e.g. the Australian Institute of Health and Welfare and Heart Foundation), the reader should always carefully critically analyse the document and its source before accepting the findings.

ONLINE PORTALS

Traditionally, research findings were only available in scientific journals and in presentations at scientific meetings, so they were largely unavailable to end-users including patients, researchers and clinicians from low-income countries who may not have access to traditional academic journals. Today, thanks to the growth of the internet, researchers are able to publish their findings to a much broader audience (Ross & Cross 2019). Platforms such as Twitter, ResearchGate and news websites like The Conversation are increasingly being recognised as important tools for communication and dissemination (Dardas et al 2019). Like all other sources, information gathered from online portals should always be critically analysed before the information is accepted and used.

REFLECTION

What strategies can you use to access peer-reviewed journals and grey literature?

CONCLUSION

An understanding of basic concepts and processes in research is central to professional nursing practice. Quality nursing care is based on applying the best available evidence, using professional clinical judgement and incorporating individual and community preferences. All nurses require research utilisation skills in order to make judgements about how relevant and applicable research findings are to practice. Nursing is a complex, practice-based discipline in which researchable questions will always require answers in order to extend our knowledge base. For this reason, some nurses will move beyond utilising research to inform their work and become involved in the conduct and development of nursing and/or interdisciplinary research. This is an exciting career path that can open a range of opportunities.

An array of research paradigms, methodologies and methods are available to appropriately answer the range of questions facing the nursing profession. As the content of this chapter is introductory, you can expect to learn more about the various research traditions, paradigms, methodologies and methods during your undergraduate education. It is important that as nurses we take responsibility for ensuring that we are sufficiently skilled in research to enable us to meet regulatory requirements and optimise our contribution to the nursing profession and the individuals, families and communities who rely on our work.

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CHAPTER 8: ETHICS IN NURSING

Megan-Jane Johnstone

KEY WORDS

ethical and; unethical; professional; conduct; ethics; humanitarian; concerns; megatrends; moral wisdom; nursing ethics; responsibility; whole-of-world/whole-of-society; scenarios

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- clarify the relationship between professional ethics and nursing ethics;
- define ethical and unethical professional conduct in nursing;
- consider the role and responsibilities of the nursing profession in responding to the ethical issues posed by the challenging contexts in which they will be working.

INTRODUCTION

Ethics in nursing has never been more important than it is today. Faced with competing values, beliefs and viewpoints in the workplace and society generally, deciding the 'right' moral course to take in given situations has become increasingly difficult for nurses. To help overcome this difficulty and to enable them to promote the wellbeing of patients through the delivery of *good nursing care*—the ultimate goal of nursing—it is essential that nurses have at least a working knowledge and understanding of nursing ethics and its application in everyday practice. To this end, in the discussion to follow, attention will be given to clarifying the nature and importance of professional ethics and its relationship to nursing ethics; defining ethical and unethical professional conduct; considering the kinds of 'everyday' ethical issues nurses may face; and, finally, to identifying a range of local and global challenges that will test the moral wisdom of nurses and the capacity of the nursing profession as a whole to respond to the challenges posed in morally just ways.

Professional ethics

It has long been recognised that ethical standards and exemplary ethical conduct constitute the hallmarks of a profession. Professions are expected not only to operate under strict ethical standards but also to discipline members who violate those standards. Nursing as a profession is no exception in this regard. Upon entering the nursing profession, members are expected to uphold the most stringent standards of ethical professional conduct and can expect to be held to account and to be disciplined if and when they fail to uphold those standards, even if a violation occurs unintentionally. These expectations derive from the potential vulnerability of people requiring and receiving nursing care and the special obligation that nurses have to protect patients from harm when working in a professional capacity.

In order to understand why members of the nursing profession must adhere to exemplary standards of ethical professional conduct it would be helpful to first briefly outline the nature of nursing ethics and then to define what constitutes ethical professional conduct and unethical professional conduct in a nursing context.

Nursing ethics

Nursing ethics (to be distinguished from medical ethics) can be defined broadly as 'the examination of all kinds of ethical and bioethical issues from the perspective of nursing theory and practice' (Johnstone 2019:17). In turn, these issues rest on a fundamental understanding of the foundational concepts of nursing: person, culture, care, health, healing, environment and nursing itself (i.e. what it is and what its end and purpose is). Unlike other approaches to ethics (e.g. medical ethics, bioethics), nursing ethics recognises the 'distinctive voices' that are nurses' and emphasises, as a starting point for systematic ethical inquiry, the importance of nurses' *actual experiences* as opposed to

hypothetical examples or the experiences of members from other disciplines, which are not always relevant to nursing or to advancing moral wisdom in the practice of nursing.

Ethics functions by providing an authoritative action guide on how to think about, understand, examine and judge how best to 'be moral' and live the moral life. When applied in professional practice contexts, ethics functions in two key ways:

- by *ascribing* moral values to things (e.g. 'it is wrong to cause harm to patients')
- by prompting us to consider and reconsider *what* we have judged to be 'right' and 'wrong' as well as the *justifications* we have used to support and defend those judgements (e.g. 'this action is morally wrong *because* it violates the moral principle of "do no harm" ').

Authoritative action guides to ethical decision making and conduct are found in the principles and rules expressed in commonly accepted theories of ethics; for example, utilitarianism, human rights theory, moral rights theory, ethical principlism and virtue ethics (see Table 8.1)—all of which have informed the development of nursing ethics and which have been comprehensively discussed in the nursing literature and expressed variously in nursing codes of ethics (Johnstone 2019).

TABLE 8.1

Common theories of ethics*

MORAL THEORY	EXPLANATORY NOTE
Utilitarianism	A moral theory that positions the general welfare and interests of people *as a whole* above that of the individual; classically advocates achievement of 'the greatest good for the greatest number'.
Human rights	A special entitlement or interest that all people are believed to have simply by virtue of being human—e.g. the right to an education, to freedom of thought, etc.
Moral rights	A special entitlement or vital interest that an entity has and which ought to be protected for moral reasons—for example, the right to be respected, fair treatment, privacy, confidentiality, etc.
Ethical principlism	A system of conduct guiding principles that specify some types of actions are either required, prohibited or permitted. Ethical principles commonly appealed to include: • autonomy—respect others as self-determining choosers • beneficence—do good • non-maleficence—do no harm • justice—be fair and equitable.
Virtue ethics (also called character ethics)	The quality or practice of 'moral excellence'; examples include: altruism, caring, compassion, courage, diligence, empathy, kindness, trustworthiness.

*Further discussion on these theoretical perspectives can be found in Johnstone 2019, Chapter 3 'Moral theory and the ethical practice of nursing'; see also Beauchamp and Childress 2019 Principles of Biomedical Ethics, 8th edn. Oxford University Press, New York.

Some nurses might think it unnecessary to appeal to 'high-brow' theoretical approaches (e.g. human rights, moral rights, ethical principlism, virtue ethics, etc.) in their practice, preferring instead to draw on their own personal moral values, beliefs and experiences when dealing with ethical issues. While such a stance might serve them

well when caring for their own loved ones, its application in a professional context is limited—especially when caring for people whose culture and lifeways are unfamiliar to them. Not only might a reliance on personal ethics lead to moral mistakes being made, but, worse, to errors of moral judgement that result in morally harmful and even catastrophic outcomes.

Ethical and unethical professional conduct

As stated in the opening paragraph to this chapter, exemplary ethical conduct is an important hallmark of a profession. But what is exemplary ethical conduct?

Exemplary or prototypical ethical professional conduct can be broadly defined as conduct or behaviour that complies with the agreed and expected ethical standards of a profession. Because the ethical standards of a profession tend to require a level of behaviour and demeanour that is above that ordinarily expected of lay people or 'the ordinary person on the street', it is also deemed to be 'ideal', 'archetypal' and, hence, 'exemplary'. By this view, ethical professional conduct in nursing can be defined as conduct by a nurse that complies with the agreed ethical standards of the nursing profession and, by virtue of being characteristic of the ideals that the nursing profession 'professes', is both exemplary and 'right'.

The exemplary ethical standards that registered nurses are expected to uphold are contained in various formal codes and guidelines relevant to the profession and practice of nursing. In Australia, the standards pertaining to moral conduct expected of registered nurses are contained in the International Council of Nurses' (ICN's) 2012 *Code of Ethics for Nurses.* It should be noted that the ICN *Code of Ethics for Nurses* was formally adopted by Australian nursing organisations in 2018 and superseded the Nursing and Midwifery Board of Australia's (NMBA's) *Code of Ethics for Nurses in Australia* (NMBA 2008), which is now redundant (Johnstone 2019:4). The ICN Code is to be read, interpreted and applied in conjunction with the NMBA's *Registered Nurse Standards for Practice* (NMBA 2016). In New Zealand, the specific standards pertaining to moral conduct expected of registered nurses are given in the Nursing Council of New Zealand's (NCNZ's) *Code of Conduct for Nurses* (NCNZ 2012) and *Competencies for Registered Nurses* (NCNZ 2016) and the New Zealand Nurses Organisation's (NZNO's) *Guideline—Code of Ethics* (NZNO 2019).

These and related standards/guidelines work by setting the 'ethical baseline' against which a nurse's conduct can be measured and evaluated. Thus, if a nurse engages in conduct that breaches the agreed standards of the profession (fails literally to 'measure up' to the standards in question) this may be deemed as unethical professional conduct and may result in a notification being made, in the case of Australian nurses, to the Australian Health Practitioner Regulation Agency (AHPRA) and, in the case of New Zealand nurses, to the NCNZ. If a notification is received by AHPRA, the nurse may be investigated by the NMBA (which works in partnership with AHPRA) to ensure that the necessary action is taken to protect the public. Likewise in the case of notifications received by the NCNZ, which also has regulatory authority to investigate a nurse's conduct.

Unethical professional conduct is more complex than a mere failure to comply with

agreed ethical standards, however. Unethical professional conduct may be more comprehensively defined as an umbrella term that incorporates the following three related although distinct notions: (i) unethical conduct, (ii) moral incompetence and (iii) moral impairment (Johnstone 2019). Here, *unethical conduct* may be defined as 'any act involving the deliberate violation of accepted or agreed ethical standards' and can encompass both 'moral turpitude' and 'moral delinquency' (Johnstone 2019:6). *Moral turpitude* refers to 'conduct that is considered contrary to community standards of justice, honesty or good morals' (Legal Dictionary 2016; see also Wikipedia 2018). *Moral delinquency*, in turn, refers to any act involving moral negligence or a dereliction of moral duty. In professional contexts, moral delinquency entails a deliberate or careless violation of agreed standards of ethical professional conduct.

Moral incompetence (analogous to clinical incompetence) pertains to a person's lack of requisite moral knowledge, skills, 'right attitude' and soundness of moral judgements (Johnstone 2019, see also Johnstone 2015a). *Moral impairment* meanwhile is generally distinguished from moral incompetence. Unlike moral incompetence (attributable to a lack of moral knowledge, skills), moral impairment entails a disorder; for example, psychopathy, that interferes with a person's social and moral reasoning and hence capacity to behave ethically. More specifically, because of their impaired moral reasoning, they are unable to engage in the competent discharge of their moral duties and responsibilities towards others. Accepting the notion of moral impairment (a notion which has received little attention in the nursing literature), a nurse could be judged morally impaired when, because of their disorder, they are unable to practise nursing in an ethically just and morally accountable manner (Johnstone 2019).

'Everyday' ethical issues in nursing

It is important to understand that ethical issues in nursing and healthcare contexts do not only involve the so-called 'big' or 'exotic' issues (e.g. abortion, euthanasia); they also involve fundamental questions about the nature and quality of professional–client relationships. This includes examining the more fundamental day-to-day practical ethical concerns relating to the precise impact that nurses' decisions and actions (or non-actions) have on the lives and welfare of other human beings, and the capacity of nurses to do harm to others while acting in a professional capacity.

The kinds of ethical issues faced by nurses today are as complex as they are varied. While in the past attention has tended to be focused on the better known bioethical issues such as abortion, euthanasia, organ transplantation, reproductive technology, genetic engineering and the like, over the past four decades there has been a significant shift in attention towards examining the other kinds of ethical issues faced by nurses. These issues include:

- 'everyday' practical ethical issues faced by nurses
- a genuine *nursing* perspective on common mainstream bioethical issues, and

- (the otherwise neglected) broader social justice issues associated with promoting the welfare, wellbeing and significant moral interests of highly vulnerable, stigmatised and marginalised groups of people.

The nursing ethics literature has borrowed heavily from bioethics to shape nursing ethics discourse. As a result, the nursing ethics literature does not always represent or reflect the reality of the 'everyday' problems that nurses face. Some examples of the ethical issues that nurses may commonly encounter during the course of their practice include:

- *the moral boundaries of nursing* (e.g. nurses as carers being 'in relationship' with others, as opposed to being detached, 'impartial' observers operating at arm's length from those in their care)

- *catalysts to moral action* (e.g. 'experiential triggers' such as 'the look of suffering in a patient's eyes', as opposed to abstract moral rules and principles)

- *operating moral values* (e.g. sympathy, empathy, compassion, kindness, human understanding and a desire 'to do the best we can', rather than an obsession to 'do one's duty')

- *ethical decision-making processes* (which tend to be collaborative, communicative, communal and contextualised, rather than independent, private, individual, solo and decontextualised)

- *barriers to ethical practice* (which tend to be structural rather than knowledge-based; for example, organisational norms forcing compliance with the status quo, and negative attitudes and a lack of support from co-workers and managers), and

- *need for cathartic moral talking* (e.g. 'talking through' moral concerns in a safe and supportive environment to help relieve the distress that so often arises as a result of trying to be moral in a world that appears to be growing increasingly amoral) (Johnstone 2019:127).

What talking with nurses often reveals is that it is not the so-called paramount ('exotic') bioethical issues that trouble them, but the more fundamental issues of:

- how to help a patient in distress in the 'here and now'

- how to stop 'things going bad for a patient'

- how to best support a relative or chosen carer during times of distress and when the 'system' appears to be against them
- how to make things 'less traumatic' for someone who is suffering
- how to reduce the anxiety and vulnerability of the people being cared for
- where nurses can get help for their own distress, and
- how to make a difference in contexts where indifference to the moral interests of others is manifest (Johnstone 2019:127).

The above and other related concerns are all issues worthy of attention and consideration within and outside of the nursing profession. They are also issues that deserve to be recognised as being an integral part of a sound moral framework and approach that might be appropriately described as 'nursing ethics'.

Future ethical challenges

Over the past century nursing ethics as a field of systematic inquiry has developed in impressive ways. Initially concerned only with polite commentaries in the early nursing journals, nursing ethics is now the subject of a vast body of scholarly literature and is widely recognised as a distinct field of inquiry and practice in its own right (Johnstone 2015b, 2015c, 2015d). The substantive and ever-expanding body of work by scholars in the field informs the ongoing advancement of the ethical standards and practice of the nursing profession, and continues to identify and foster understanding of the complex array of ethical issues faced by nurses in their day-to-day practice. Despite its historical progress, the project of 'nursing ethics' is not yet complete and, when considered in its broadest sense, is unlikely to be completed in any one lifetime (Dock 1900). This is because, as contemporary contexts change, so too must nursing ethics change and continue to develop if it is to remain compelling and relevant as a discipline and guide to ethical nursing conduct.

There is recognition internationally that healthcare services around the world are facing a range of complex challenges, the immediate and future impact of which cannot be ignored. Included among the list of challenges identified are the:

- growth and increasing diversity of populations with a complex mix of chronic and acute diseases and associated burdens ('burden of disease')
- impact of diverse healthcare needs on resources—including infrastructure, supplies, knowledge, skills and information
- disparities and inequalities in health (particularly among the poor,

Indigenous, immigrant and refugee populations) (see Renzaho et al 2016)

- changing needs and expectations of people in regard to their health and healthcare

- projected unprecedented financial constraints on healthcare that are unlikely to lessen in the immediate future and challenges posed by associated demands for the equitable allocation and distribution of resources

- 'old' challenges of leadership and governance (Roncarolo et al 2017).

In addition, scholars in the field have identified several 'megatrends' which, they argue, are poised to 'fundamentally disrupt our current notions of health and health care delivery' (Day 2015:487). Included among the megatrends identified are:

- a digital future (encompassing electronic health records and the move to fully digitalised health services)

- rising entrepreneurship (creating challenges for health service managers and policy makers concerned with cost containment, standards and regulation processes)

- a global marketplace (driving workforce diversity, role change and substitution, raising critical questions concerning traditional professional boundaries, staff recruitment, staffing levels, skill mix, minimum standards of practice and competencies)

- an increasingly urbanised world (placing increasing emphasis on the need for more efficient use of scarce resources)

- consumerism and the demand for resources (and the challenges of sustainability as consumerism drives demand for greater access to resources and services)

- re-imagined health (involving a shift from 'sick care' to the 'management of health', and the redesign of the healthcare system to deal with this shift) (Day 2015:487; see also Charlesworth et al 2015, Horton et al 2018).

In addition to the above megatrends, there are a number of 'whole-of-world' and 'whole-of-society' scenarios that also need to be taken into consideration and which are likewise poised to have a profound impact on people's notions of health and healthcare.

Notable among the whole-of-world/society scenarios facing people are the anticipated and projected negative health impacts of: climate change (World Health Organization [WHO], 2015a, 2018), pandemic influenza (WHO 2007, 2017), antimicrobial resistance (colloquially referred to as 'drug resistant bugs') (WHO 2015b) and the capacity of these things individually and collectively to contribute to inequalities in health and healthcare —particularly among vulnerable populations (Johnstone 2019). As the impact of these scenarios is felt around the world, people's health security will also shift as will the social protections they will need and come to expect in order to safeguard this (Gama 2016).

The above scenarios are already re-shaping the moral landscape in which nursing and healthcare is practised. In light of the changes that are occurring, the most pressing ethical issues that nurses and their co-workers are likely to face in the future will not be of the conventional kind more commonly associated with the big 'exotic' issues of bioethics (e.g. abortion, euthanasia, end-of-life care, reproductive technology, informed consent, etc.). Rather they will be issues that extend far beyond the parameters of the 'bricks and mortar' walls of hospitals to encompass much broader social justice and humanitarian concerns. Notable among these concerns will be a range of issues generated by the continual unfolding of whole-of-world/whole-of-society scenarios and the tough moral choices that will need to be made about the rationing, restrictions and responsibilities associated with the provision of healthcare and the tragic trade-offs that will sometimes need to be made in the changing contexts over which nurses will often have little control (Johnstone & Turale 2014).

What can nurses do?

As healthcare providers, nurses have a fundamental role to play in helping to guide a just and humanitarian response to the ethical issues that projected 'megatrends' and 'whole-of-world'/'whole-of-society' scenarios will inevitably give rise to. To this end, nurses need to think more broadly and creatively about ethics in general and to rethink the conventional (bio)ethical frameworks they have used in the past to ascertain and justify what is 'the right thing to do' in given situations. On this point, engaging with the relatively new discipline of public health ethics offers a way forward. Of particular note is the emergence of robust debate on the development of concepts thought vital to public health ethics but which, to date, have largely been neglected, notably: *membership* (encompassing people's 'equal rights of membership and reciprocal recognition in communities of health justice'); *solidarity* (encompassing a 'cultural sense of obligation and mutual aid in a world of common vulnerability'); and *place* or *'habitus'* (encompassing 'the schemata of human thinking, the patterns and defaults of human lives and behavior, the underlying assumptions and meanings that make certain types of behavior seem appropriate under the circumstances') (Jennings 2015, 2019, Jennings & Dawson 2015).

A second strategy is for nurses to form alliances with other health professional groups and to collectively 'speak out' on matters that are an affront to the ethical standing and humanitarian values of the professional groups involved (e.g. punitive legislative provisions gagging nurses and others from speaking out about the inhumane

conditions being endured by asylum seekers and refugees detained indefinitely in off-shore detention centres—see Walsh 2015).

Nursing is fundamentally concerned with caring about fellow human beings. It is our job to provide comfort and care to those who are wounded, distressed and suffering. In addition to our professional obligations, we also have a civic responsibility to help make the world a better place within which to live and work. In the end, what we, as nurses, do about the social justice and humanitarian issues we encounter will reflect what kind of profession we are; and what we think ought to be done about the social justice and humanitarian issues we encounter will ultimately reflect what kind of profession we think we ought to be. It is hoped that by reflecting on the moral challenges that lie ahead, nurses will cultivate new insights and a new moral wisdom about the ethical issues they will face both now and in the future, and become inspired to be much more than mere 'morally passive bystanders' in the world of human affairs and to take a stand on the things that really matter.

CONCLUSION

This chapter has sought to clarify the nature and importance of professional ethics in nursing and to identify some of the moral challenges that will confront nurses in the future. It is important to understand, however, that ethics neither emerges from nor operates in a cultural or contextual vacuum, and that its processes (thinking, reasoning, doing) are vulnerable to all sorts of corrupting influences, including politics, prejudice and personal needs. These influences can result in decision making that is arbitrary, biased, capricious, self-interested and precariously based on personal preferences. It is for this reason that proper 'checks and balances' need to be in place that, in turn, are supported by an appropriate infrastructure (policies, processes and procedures).

Whether nursing ethics is 'up to the task' of guiding sound ethical decision making in the healthcare contexts of the future will depend ultimately on its capacity to:

- offer moral insight
- foster moral wisdom
- inform 'good policy'
- provide 'real' solutions to complex problems
- warrant principled dissent against questionable policies, decisions and actions by others
- enable foresight
- guide the prevention of future problems (preventative ethics)
- redress the harms caused by past problems (restorative ethics) (Johnstone 2019).

There are numerous complexities involved in building the capacity of nurses and nursing ethics to meet the inherent challenges that nurses can and do face during the course of their work. In order to meet these challenges responsibly and effectively, nurses have a professional obligation to advance their knowledge and understanding of what they can do to ensure that their decisions and actions are morally justified and will achieve their intended moral outcomes. Fulfilling this obligation will enable nurses to achieve the best possible position from which to practise and lead as ethical professionals.

REFLECTIVE QUESTIONS

1. Nurses are faced with ethical issues every day. In your view, what are the most pertinent and pressing ethical issues facing nurses today? How might nurses best deal with these issues?
2. How, if at all, might the study of nursing ethics assist nurses to practise nursing in a morally wise, insightful, just, effective and responsible manner?
3. What should a nurse do if she or he witnesses an instance of unethical professional conduct by either a nurse or other health professional? How would you assess that the conduct in question was, in fact, unethical? Would you report the matter to an appropriate authority? How would you approach this responsibility?
4. In your view what are some standout 'whole-of-world'/'whole-of-society' issues at the present time? To what extent do these issues warrant the nursing profession's attention and action? What would you be willing to do? On what grounds would you justify your actions or non-actions as the case may be?

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CHAPTER 9: AN INTRODUCTION TO LEGAL ASPECTS OF NURSING AND MIDWIFERY PRACTICE

Amanda Adrian

KEY WORDS

Assault; common law; complaints; conduct; consent; duty of care; ethics; health law; health; professional; regulation; legislation; negligence; precedents; safety standards; and codes

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand the basics of the Australian legal system;
- understand basic principles of law and regulation applicable to nursing and midwifery practice;
- understand the legal rights of patients, women and their infants;
- understand the role of the criminal law in nursing and midwifery practice;
- understand specific regulation governing the registration and standards for the professions of nursing and midwifery.

INTRODUCTION

The provision of nursing and midwifery care takes place within an environment that is regulated by the law and the legal system. It is important, therefore, that nurses and midwives are aware of the legislation, regulations and decisions from the tribunals and courts that both prescribe and impact on their practice. An understanding of the laws, relevant to the provision of healthcare services, is fundamental to ensuring safe and competent patient care. The term 'health law' has developed over time and is used to describe the particular, but expanding, area of law that regulates the standards and delivery of healthcare services by healthcare professionals and services.

Nurses and midwives must be aware of, and incorporate into their clinical decisions, the legal implications of their practice. (The titles of 'nurse' and 'midwife' are protected in Australia under the Health Practitioner Regulation National Law Act 2009; the particular issues addressed in this chapter apply to both professions. For ease of reading, the term 'National Law' will be used to refer to the Act throughout this chapter.) Legal action, in the forms of litigation or professional disciplinary proceedings against healthcare professionals, across all health disciplines, has increased as healthcare consumers become more aware of their legal rights and the law develops to recognise and acknowledge a wider range of factual circumstances that can potentially give rise to a legal action. For example, while an employer of a nurse or midwife may be held to be vicariously liable for the wrongdoing of a nurse or midwife where harm occurs (tort) during the course of their employment, this does not absolve the nurse or midwife from responsibility for their actions. Nurses and midwives working independently or employed nurses and midwives acting outside of the scope of their employment who cause harm to patients can be held to be fully liable for their actions. Likewise, an employer may not be held vicariously liable for criminal acts committed by their employees in the course of their employment. In addition, the professional regulatory authority for nurses, midwives and enrolled nurses, the Nursing and Midwifery Board of Australia (NMBA), also plays a major and significant role in maintaining professional standards and protecting the public from risk of harm.

This chapter serves as an introduction to the legal system, laws and regulation relevant to nursing and midwifery practice. This introduction, however, is necessarily brief and cannot cover all aspects of the law that affect nursing and midwifery practice. The law evolves over time and changes are made as required, particularly in relation to legislation. Nurses and midwives should keep up to date and develop a deeper understanding of the legal system in which they work, and the laws that govern their clinical practice, through active participation in continuing professional development (CPD), clinical research and education. The aim of this chapter is to highlight to nurses and midwives the legal issues that may arise in the course of their nursing or midwifery career and to assist them to understand the law relevant to those issues.

It should be noted that for most practising nurses and midwives, their major contact with the legal system is through the national regulatory system governing the registration, accreditation of education programs, standards of practice and conduct of

health professionals; however, having a broader understanding of where this evolved from and how it continues to impact on health professionals is important.

Common law

The common law was developed in England in the centuries after the Norman Conquest in 1066 and became the basis of the legal systems of countries that were colonised by England.

The primary source of law in common law countries is a combination of common law, equity and legislation. Common law is judge-made law and consists of the application of legal principles developed in past cases to determine the outcome of present cases. *Common law* is based upon the doctrine of precedent (i.e. by looking at how cases have been decided in the past and applying the principles developed in those cases to the present). Cases that have an important impact on the common law are reported in law reports relevant to particular courts. Less important cases are unreported but can still be accessed.

The common law remains a significant source of law covering clinical practice. For example, the law relating to assault, false imprisonment and negligence is found within cases in which relevant principles of law recognising the right of a person to individual autonomy and bodily integrity have been developed. A court exercising equity can provide an alternative remedy where a common law remedy is insufficient to redress the wrong complained of. A court exercising an equitable jurisdiction can issue an injunction to require another to desist from doing something, or can make an order for specific performance to a defaulting party under a valid contract to cause them to perform their part of the contract.

The second type of law is *legislation,* or statutory law. This is law developed by parliamentarians through the parliamentary processes at federal, state and territory levels. An individual piece of legislation is referred to as a statute or an Act of parliament. Legislation is important in that valid legislative provisions prevail where there is any inconsistency with the common law. Thus, parliamentary law can be used to change the law where it is considered that the common law is deficient or to govern new circumstances that have arisen. A new piece of legislation can be enacted, or an older one can be repealed, in which case the common law is the governing law unless a new statute replaces the older statute. Legislation can also be amended, which means that some provisions can be deleted, changed or new provisions added. Increasingly, statutory law is being applied to common law issues such as negligence.

Legislation can create new law that is not known at common law. An example of this is the statutory definition of death, which has enabled the removal of organs from a person whose brain has ceased to function but whose heart and lung activity is being sustained artificially; that is, section 33 of the Human Tissue Act 1983 (NSW) provides that a 'person has died when there has occurred: (a) irreversible cessation of all functions of the person's brain, or (b) irreversible cessation of circulation of blood in the person's body'.

Nurses and midwives practising in Australia need to be aware that, under the Australian system of Federation, the law can and often does differ from state to state or

territory. As well as state-by-state and territory differences, the federal government has power, by virtue of the Constitution, to make laws that are binding on all states and territories (i.e. the Commonwealth of Australia Constitution Act 1901). In some cases, this law-making power is exclusive to the federal government (e.g. the foreign affairs and defence powers). In other cases, the states and territories have a concurrent power to make law (e.g. taxation). However, in the latter case, a federal law will override a state/territory law where the federal law is intended to cover the field or there is an inconsistency between a valid federal law and a state/territory law (section 109 Constitution). The states and territories have residual power to make laws in all cases where the federal government has no power under the Constitution, express or implied, to do so. Most health law, such as the regulation of hospitals and other health services, falls within state/territory law.

Differences in law from state to state and territory are less obvious in common law cases. It is within parliamentary law that significant differences can arise. Legislation in one jurisdiction (state/territory) does not bind people in another jurisdiction unless the legislation has valid extraterritorial application. Even in this latter case, there must be some connection with the state/territory passing the law. A person who commits an offence in one state or territory and moves to another has to return or be extradited from the latter state if they are to stand trial in the state where the offence was committed.

Individual states and territories may enact parliamentary law to govern particular matters, while other states and territories may leave such matters to be covered by common law. For example, not all states and territories have legislated to control the reproductive technologies and the legislation is not identical in those that have. When it is deemed desirable to do so, each state or territory will enact uniform (identical) legislation to avert what can be regarded as forum-shopping (e.g. defamation laws).

Law is divided into civil and criminal. *Civil law* involves legal actions taken by a complainant (plaintiff) against another or others seeking a civil remedy for a legally recognised wrong—for example, a plaintiff seeking compensation for injury sustained as a result of a nurse or midwife giving an incorrect medication. The negligent practitioner is normally referred to as the defendant in the case. The task (onus) of proving the case rests with the plaintiff 'on the balance of probabilities'.

Other than federal crimes, much criminal law is specific to a state or territory. Most *criminal law* consists of prosecutions brought on behalf of the state or territory to punish breaches of criminal offences, and a guilty verdict results in a fine and/or custodial sentence. The onus of proving a criminal offence lies with the prosecution, which must prove its case 'beyond a reasonable doubt'. The criminal offences of murder, manslaughter, grievous bodily harm and criminal negligence are some of the major criminal offences that can apply to nursing and midwifery practice.

Legislation in all jurisdictions provides for limitation periods to apply for civil claims in the courts (e.g. Limitation Act 1969 (NSW)). An aggrieved party must commence an action within the specified limitation period; otherwise the claim will become statute barred. Limitation periods vary from jurisdiction to jurisdiction, but most are around three to six years after the cause of action arises, or, in some cases, when the plaintiff

first becomes aware that a cause of action exists. Notwithstanding that a limitation period has lapsed, it is possible to apply to a court to extend a limitation period in prescribed circumstances (e.g. a person who contracts HIV through a blood transfusion may not be aware that they have contracted the disease until sometime after the expiration of a limitation period).

Whatever limitation period applies, most jurisdictions suspend the limitation period while an injured party is a minor. Therefore, a child who suffers an injury as a result of alleged negligence may not be affected by a limitation period until reaching the age of majority (18 years of age). A person acting as 'tutor' for the child may take action on behalf of the child in the child's name prior to majority. If this is done, the evidence necessary to prove the case is more easily available sooner after the event than later.

Unless specifically stated, no limitation periods apply to most criminal offences. Thus, a nurse or midwife who causes the death of a patient intentionally or recklessly could be charged with murder or manslaughter many years after the event should evidence to support such a charge arise.

Civil law

As noted above, civil law involves legal actions taken by the plaintiff(s) against another or others (defendant(s)) seeking a civil remedy for a legally recognised wrong. Nurses and midwives need to work within the context of civil law, as it relates to: patient safety; negligent advice; patient consent; patient freedom of movement; and patients' property.

PATIENT SAFETY

By the very nature of their practice, nurses and midwives are engaged in close physical contact with patients, women, their infants and families. In providing nursing and midwifery care, nurses and midwives have a duty of care to take reasonable steps to ensure their actions or omissions do not cause reasonably foreseeable harm to those they are caring for. Some of the procedures performed by nurses and midwives pose risks to patients, women and their infants should the procedures be performed without due care and skill. If a person suffers harm as a result of a midwife's or nurse's failure to perform midwifery or nursing responsibilities at the standard to be expected of the nurse or midwife in the circumstances, then the person or their representative has a right to sue in negligence to recover compensation.

Negligence is a *tort,* which means a civil wrong resulting in an injury of some kind. The tort of negligence arises from the common law and is a means by which a person who suffers injury through a negligent act or omission can obtain compensation from the person responsible for the injury. To succeed in an action of negligence against a nurse or midwife, the plaintiff must prove, on the balance of probabilities, that the nurse or midwife was negligent. To do that, the plaintiff must prove that:

1. the nurse or midwife owed the person a legal duty of care

2. the nurse or midwife breached this duty of care

3. the person suffered harm as a result of that breach.

The plaintiff must prove each and every one of these elements. Any act or omission that is not found to be negligent is referred to as an unavoidable accident or was caused by some other factor independent of the midwife's or nurse's action.

In reaching a decision as to whether or not there is a legal duty of care, the courts resort to a test of foreseeability. Thus, a duty of care can be shown to exist when a person can reasonably foresee that their acts or omissions are likely to place another at risk. In a healthcare context, a midwife/nurse–patient therapeutic relationship, in all but the most unusual circumstances, will evidence the existence of a duty of care. In the case of *Donoghue v Stevenson* [1932] AC 562, Lord Atkin stated at 580:

> *You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in my contemplation as being so affected when I am directing my mind to the acts or omissions which are called into question.*

As the patient, woman or infant is a person whom the nurse or midwife can reasonably foresee as likely to be injured if reasonable care is not exercised, there is a legally recognised relationship which gives rise to a duty of care. 'That duty is a single comprehensive duty covering all the ways in which a doctor (and all other health professionals) is called upon to exercise his skill and judgement …' (*Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 at 483 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

The requirement of the reasonable foreseeability of harm is an objective test: was the plaintiff foreseeable as an individual, or a member of a class of persons to whom the duty is owed, and was the risk of harm which eventuated foreseeable? The existence of a duty of care is not confined to the direct nurse–patient or midwife–woman-or-infant relationship but may extend so as to include individuals who have not been formally admitted as a patient or client into the healthcare service (see *Alexander v Heise* [2001] NSWCA 422), third parties (see *BT (as Administratix of the Estate of the Late AT) v Oei* [1999] NSWSC 1082) and unborn infants (see *Kosky v Trustees of the Sisters of Charity* [1982] VR 961).

The case of *McKenna v Hunter and New England Local Health District: Simon v Hunter and New England Local Health District* [2013] NSWCA 476 is an example of the duty owed by health professionals and healthcare services to third parties. In this case, the doctor released a patient from a mental health facility into the care of a man whom he later killed. The court held that the doctor and the hospital were negligent. The court found there was a breach of the duty of care by the doctor and hospital to take reasonable care to prevent the mentally ill man from causing physical harm to another person when there is a foreseeable and not insignificant risk of the particular patient causing such

harm. The wife and sister of the deceased successfully established that the damage suffered by their deceased relative, and therefore themselves, was causally related to the negligence of the doctor and the hospital.

Once a duty of care is established, the plaintiff must prove, on the balance of probabilities, that the defendant did something, or failed to do something, which amounted to a breach of that duty of care. Whether or not a breach of the duty of care has occurred requires consideration of the standard of care required in the circumstances. Legislation, in all jurisdictions other than the Northern Territory (NT), provides guidance in relation to breach of a general duty of care (Australian Capital Territory (ACT): Civil Law (Wrongs) Act 2002; New South Wales (NSW): Civil Liability Act 2002; Queensland (Qld): Civil Liability Act 2003; South Australia (SA): Civil Liability Act 1936; Tasmania (Tas): Civil Liability Act 2002; Victoria (Vic): Wrongs Act 1958; Western Australia (WA): Civil Liability Act 2002). The legislative provisions confirm that a person will not be negligent in failing to take precautions against the risk of harm unless the risk was foreseeable, the risk was not insignificant and, in the circumstances, a reasonable person in the person's position would have taken those precautions. As an example the Civil Liability Act 2003 (Qld) provides at section 9:

(1) A person does not breach a duty to take precautions against a risk of harm unless—

(a) the risk is foreseeable (that is, it is a risk of which the person knew or ought reasonably have known); and

(b) the risk was not insignificant; and

(c) in the circumstances, a person in the position of the person would have taken the precautions.

(2) In deciding whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (among other relevant things)—

(a) the probability that the harm would occur if the care were not taken;

(b) the likely seriousness of the harm;

(c) the burden of taking precautions to avoid the risk of harm;

(d) the social utility of the activity that creates the risk of harm.

When considering the standard of care required from skilled professionals such as nurses, midwives and doctors, the case law (see *Bolam v Friern Hospital Management*

Committee [1975] 1 WLR 582 and *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479) and civil liability legislation provide the benchmark against which the conduct will be considered. The standard of care is not perfect care, but reasonable care. It is an objective test and therefore is not dependent upon the particular skills and knowledge of the practitioner. The standard expected of the healthcare worker is that which is attributed to the class of healthcare workers to which the defendant belongs. Thus, the conduct of a nurse or midwife will be measured against that of the hypothetical reasonably competent nurse or midwife. It is when the defendant's standard of care falls below that of the reasonably competent nurse or midwife that a breach of care is found.

Nurses and midwives who claim to have special skills will be required to exhibit a higher standard of care. Thus, the clinical nurse specialist will be measured against the standard of the reasonably competent clinical nurse specialist, while the general ward staff will be measured against the standard expected of the reasonably proficient general ward nurse. An enrolled nurse's practice will be measured against that of the reasonably competent enrolled nurse. The acts of a midwife of many years of active practice and education will be measured against a peer with equivalent skills, knowledge, judgement and care. Civil liability legislation, in all Australian jurisdictions other than the Northern Territory, provides the standard of care for professionals. While the legislation adopts the case law (as described above) there is a lack of uniformity across the jurisdictions and nurses and midwives should therefore familiarise themselves with the provisions in the particular state or territory in which they work. An example is section 5O of the Civil Liability Act 2002 (NSW):

Section 5O Standard of care for professionals

(1) A person practising a profession ('a professional') does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time that the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

The circumstances in which care is being provided can also be a relevant

consideration in determining the standard of care required. A nurse involved in resuscitating a person at an accident site away from a well-equipped hospital where trained staff and proper equipment is at hand can only be expected to provide the standard of care that is reasonable in the circumstances. Provided the nurse exercises reasonable care and skill in the circumstances, there would be no breach of the duty of care. The nurse's actions in this case fit under the 'good Samaritan principle' providing protection under the civil liability legislation in each Australian state and territory. For example, section 56 of the Civil Liability Act 2002 (NSW) defines a good Samaritan as 'a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured'.

Section 56 of that Act outlines the protection available for good Samaritans:

(1) A good Samaritan does not incur any personal civil liability in respect of any act or omission done or made by the good Samaritan in an emergency when assisting a person who is apparently injured or at risk of being injured.

The courts also recognise that the standard of competent professional practice continues to develop and evolve over time. The standard of care in a negligence claim will therefore be determined by the standard relevant 'at the time' the adverse event occurred and not at any future time when the proceedings come before the court.

In addition to the breach of the duty of care in relation to treatment, the civil liability legislation specifically addresses the failure, by health professionals, to disclose risk or warn patients of harm. Once again, there is no uniformity of legislative provisions between the states and territories and nurses must ensure they are familiar with the laws in their own jurisdiction. For example, section 21 of the Civil Liability Act 2003 (Qld) (which is similar to the Civil Liability Act 2002 (Tas)) imposes a proactive and reactive duty on medical practitioners to warn:

Section 21

(1) A doctor does not breach a duty owed to a patient to warn of risk, before the patient undergoes any medical form of treatment (or at the time of being given medical advice) that will involve a risk of personal injury to the patient, unless the doctor at the time fails to give or arrange to be given to the patient the following information about the risk—

(a) information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice;

(b) information that the doctor knows or ought reasonably to know the

patient wants to be given before making the decision about whether to undergo the treatment or follow the advice.

In New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia there is no duty to warn of an 'obvious risk'. Under section 5F of the New South Wales legislation this is described as:

(1) … 'obvious risk' to a person who suffers harm is a risk that, in the circumstances, would have been obvious to a reasonable person in the position of that person.

(2) Obvious risks include risks that are patent or a matter of common knowledge.

(3) A risk of something occurring can be an obvious risk even though it has a low probability of occurring.

(4) A risk can be an obvious risk even if the risk (or a condition or circumstance that gives rise to the risk) is not prominent, conspicuous or physically observable.

Damage is the gist of the case in an action of negligence; a plaintiff must prove that foreseeable damage resulted from a breach of duty by the nurse or midwife. Damage may be physical harm, psychological harm, economic harm or a combination of these. Once the plaintiff has proved that the nurse's or midwife's breach of duty caused damage that was reasonably foreseeable, the defendant will be held liable to compensate for that damage and any further loss that flows reasonably and naturally upon the initial injury. Pain and suffering, loss of enjoyment of life, loss of expectation of life, loss of opportunity in life and financial consequences are examples of accepted heads of damage (categories of damage recognised by the courts) for which compensation can be sought in a negligence action. A young woman who suffered cerebral palsy due to the admitted negligence of an obstetrician at the time of her birth was awarded around $11 million, which included a sum that would enable the plaintiff to finish her HSC and pursue some form of tertiary education (*Simpson v Diamond & Anor* [No 2] [2001] NSWSC 1048). If no harm has been caused by the negligent act or omission, then there can be no recovery of compensation.

There is a principle in law that a person must take their victim as they find them. This is called the 'egg-shell skull rule'. What it means is that if the victim suffers greater harm because they have a particular disability, disorder or trait that renders them vulnerable to greater harm, then the tortfeasor (the person who carried out the wrongful act or made the omission) must compensate for the full cost of the harm even though it is greater than that for other victims. A man who suffered a burn to his lip in a workplace accident later died when the injury turned cancerous. His employer was held

responsible for his death (*Smith v Leech Brain* [1962] 2 QB 405). An example would be harm caused by increased blood loss where the victim is a haemophiliac. In such cases it is irrelevant whether the tortfeasor was aware that the victim was particularly vulnerable.

When a plaintiff has suffered harm as a result of another's negligence, the plaintiff is required by law to minimise (mitigate) any loss. Therefore, an injured person is required to take reasonable steps to reduce the effects of (ameliorate) the harm caused. To the extent that there is an unreasonable failure to mitigate (e.g. undertake recommended physiotherapy which could improve their condition) a court will discount the amount of compensation that the plaintiff would have received.

If death occurs as a result of negligence, legislation provides that prescribed persons, usually close relatives, can bring an action against the person whose negligence caused the death (e.g. Compensation to Relatives Act 1897 (NSW)), provided the deceased would have been entitled to make a claim had they lived. For example, a man and his children may commence an action to be compensated for nervous shock suffered as a result of the death of the wife and mother caused by a negligent nursing or midwifery act or omission.

Finally, the plaintiff must prove causation—that is, that the breach of duty caused the harm now claimed. To prove a causal connection, the 'but for' test can be applied. Can it be proven that 'but for' the act or omission of the defendant, the plaintiff would not have suffered the harm? Even when an act or omission can be shown to have been negligent, a claim for damages will fail if the plaintiff cannot prove that the harm was caused or materially contributed to by the defendant's negligent conduct. The civil liability legislation in each of the states and territories, with the exception of the Northern Territory, requires a two-stage approach to finding a causal link between the act/omission and the harm. A determination that the negligence caused the harm requires that the 'negligence was a necessary condition of the occurrence of the harm ("factual causation"), and … that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused ("scope of liability")' (section 5D Civil Liability Act 2002 (NSW)). The civil liability legislation provides for the 'expression of regret' or 'apology' following an adverse event. The relevant sections (ACT: Civil Law (Wrongs) Act 2002 section 14; NSW: Civil Liability Act 2002 section 69; Qld: Civil Liability Act 2003 section 72; SA: Civil Liability Act 1936 section 75; Tas: Civil Liability Act 2002 section 7; Vic: Wrongs Act 1958 section 14 J(1); WA: Civil Liability Act 2002 section 5AH; NT: Personal Injuries (Liabilities and Damages) Act 2003 section 13) enable an expression of regret to be given, or an apology to be made, without concern that it will be used as an admission of fault or liability. Apologies and expressions of regret are not admissible as evidence in negligence cases and are supported by the Australian Open Disclosure Framework. The Open Disclosure Framework is designed to 'enable health service organisations and clinicians to communicate openly with patients when health care does not go to plan … [providing] a nationally consistent basis for communication following unexpected healthcare outcomes and harm' (Australian Commission on Safety and Quality in Health Care 2013).

Defences

The defendant in a negligence action has a number of defences available to them:

- *No duty of care*—the defendant may show there was no duty of care owed to the plaintiff.

- *No breach of the duty*—the defendant may successfully argue that their act or omission was consistent with competent professional practice and did not amount to a breach of the standard of care.

- *No causation*—the defendant may show on the evidence that their act or omission was not causally linked to the damage claimed.

- *Novus actus interveniens* (a new act intervening)—this defence is available when a second negligent act results in increased harm to a person who has suffered harm from a prior negligent act and breaks the chain of causation. However, where the second negligent act is such that the chain of causation flowing from the first negligent act is not broken, then the person who committed the first negligent act can be held liable for the consequences of both. For example, if a nurse's or midwife's negligence caused brain damage to a child, necessitating intensive care, and the negligence of a second nurse in the intensive care unit exacerbated the harm to the child, then the first nurse/midwife could still be held liable for the increased harm as it was the original tortfeasor's act or omission which exposed the child to a subsequent foreseeable risk of harm. However, if the child were discharged from hospital following the maximum care that could be given, and then dies from other injuries sustained in a motor vehicle accident caused through another's negligence, then the first nurse/midwife is unlikely to be held responsible for the death.

- *Volenti non fit injuria* (there can be no injury to the willing)—applies when a plaintiff can be shown to have knowledge of risks and voluntarily undertakes those risks. As such, this defence has not been a major factor in cases involving the provision of healthcare services. Its main application is to cases involving sports and dangerous occupations. It cannot be argued that a patient voluntarily agrees to accept all known risks in healthcare.

- *Contributory negligence*—a defendant can argue that the plaintiff was partially or totally responsible for the harm which eventuated (under the provisions of the civil liability legislation by reason of contributory negligence a court may consider a reduction of 100% with the result that the

action for damages is defeated). The court will award damages in proportion to the extent it accepts that the plaintiff was negligent. A woman who successfully sued a doctor for his failure to refer her to an alternative specialist when she advised him she was unable to use the referral he had given her had the amount of her damages reduced by 20% because of her subsequent failure to seek medical attention for four months despite suffering continued and severe vaginal bleeding (*Kalokerinos v Burnett* CA 40243/95; CL11138/93).

NEGLIGENT ADVICE

During the course of professional practice, patients ask nurses and midwives for advice and information on a whole range of matters such as diet, treatment options and how to care for themselves after discharge from hospital. In giving advice, or information, nurses and midwives must exercise a reasonable standard of care where the patient could suffer harm as a result of following the advice. Failure to exercise reasonable care in giving advice could leave a nurse or midwife open to an action in negligence.

The principles of negligence apply in the same way as described above with the courts holding that giving negligent or misleading advice or opinion can result in a finding of liability in negligence. Where the person giving the information or advice ought to have known that the recipient of that information or advice would rely on it there is a duty to take reasonable care to ensure the information is correct. A person who gives careless advice or information, gratuitously or otherwise, to another person will be liable where the other person reasonably relies on the advice and suffers a loss (see *Shaddock and Associates Pty Ltd v Parramatta City Council* (No 1) [1981] HCA 59; 50 CLR 225).

Nurses and midwives should assume that the patients will rely on the advice the nurse or midwife gives them. They must therefore ensure they are fully informed about the patient's condition and prognosis, only provide advice about issues in which they are educated, skilled and experienced, provide advice which is consistent with standard practice and accurately document the advice given and the patient's response. If a nurse is approached by a patient to provide advice on matters in which they do not have the appropriate knowledge and skill they should make it clear that this is the situation and either recommend or facilitate the patient obtaining the advice from another suitably skilled health professional.

CONSENT

Most nursing and midwifery practice involves touching people. In accordance with common law principles, all adults of sound mind have the right to determine what care, treatments or diagnostic tests they will be subjected to, unless there is some overriding law that allows treatment without consent. When a competent adult person is treated without a legally valid consent, that patient has a right to sue for assault. If a patient claims that treatment was carried out without sufficient information being given, then the patient must 'sue in negligence', the difference being that in the latter case the

patient must prove they suffered harm as a result of the treatment carried out without 'informed' consent which, as discussed above, amounts to a breach of the duty of care.

Assault (also referred to as 'trespass to the person') is a tort, which serves to protect a person's right to autonomy and self-determination. Assault consists of intentionally creating in another person an apprehension of imminent unwanted and unlawful contact. Although the actual touching of another without lawful authority is technically known as battery, the term 'assault' is now in use to represent both the apprehension of and the unlawful contact itself.

Touching in anger, even if slight, is an assault, and can amount to criminal assault. Therefore, even the slightest touching of a patient in anger can be regarded as a criminal assault. However, an assault may also be committed where a person is touched without consent and the touching is not an accepted incident of everyday life, for which a person is deemed to have given consent. Touching that occurs within a healthcare context, such as medical examinations, diagnosis and treatment procedures, is not regarded in law as an incidental touching in society; therefore, for such touching to be lawful, it must be with the patient's consent or other lawful justification.

An assault is complete once touching has occurred without lawful justification; therefore, there is no need for a patient to prove that damage occurred as a result of the touching. It is not a defence to assault that treatment was carried out in good faith for the benefit of the patient when the patient is capable of giving consent and has not done so. A nurse may have intended to benefit the patient, but this issue will only go to mitigation and does not negate an assault if treatment was carried out without consent.

The law acknowledges that there are a number of ways in which consent can be sought and obtained. The requirements for obtaining valid consent are:

1. Consent must be freely and voluntarily given.

2. Any consent given is given when the person has been provided with adequate information about the procedure, its benefits, side effects, complications and alternate treatments, and has had their questions answered.

3. The person giving consent must have the legal capacity to give it; that is, be of age (this varies from state to state or territory); and have the mental capacity to understand the intended procedure (Staunton & Chiarella 2017).

Consent may be obtained orally by asking the person's permission before commencing treatment, and receiving an affirmative response. Consent may also be implied by the person's overt physical response to suggested treatments; for example, the patient lifts their arm to have a blood pressure cuff put on when the nurse approaches with a sphygmomanometer or other blood pressure measuring device. Consent in writing, and witnessed, is usually sought for major intrusions of the body, such as surgery, labour and delivery. However, consent in writing cannot be taken to be absolute evidence of consent. In an emergency where a person is unable to give consent,

a nurse or a midwife is entitled to proceed to carry out measures that are aimed at saving life or avoiding severe injury while the emergency exists. It is usual for the person undertaking the procedure to obtain the consent.

As noted above, a patient's consent must be valid. A valid consent is one that is voluntarily given, covers the care or treatment to be carried out and is given by a legally competent person who has been given sufficient information about the procedure to be performed. A voluntary consent is one that is given freely by the patient in the absence of fraud, coercion or duress. Advising a patient of the risks and benefits of nursing or midwifery treatment is part of a nurse's and midwife's role but if the nurse or midwife becomes overbearing and the patient feels they have no choice, then the person's consent is not voluntary. A patient who wanted a general anaesthesia for surgery gave up and agreed to a spinal anaesthesia at the insistence of a doctor and suffered injuries. It was held that her consent had been overborne by the insistence of the anaesthetist and others (see *Beausoleil v Sisters of Charity* (1964) 53 DLR 2d 65). The consent must cover the treatment to be carried out, and any treatment that is related to the initial treatment. Any procedures carried out beyond that for which the patient consented (except in an emergency and the patient is incapable of giving or withholding consent) can result in a complaint of assault.

In order to give an informed consent, the person must have a good understanding of what is to be done and the risks involved. Once the patient has been advised in 'broad terms' of the nature of the procedure to be performed and agrees to it being performed, then there is no assault (see *Chatterton v Gerson* [1980] WLR 1003). However, any issue relating to the degree of information given regarding risks involved is a matter for the general law of negligence and is determined by what a patient should be told. In short, all patients should be told all 'material risks' inherent in a procedure or treatment, together with any risks that are of particular importance to the person. 'The risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective' (*Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 at 490, where a patient agreed to eye surgery on one eye without being advised that there was a remote risk she could become totally blind, which was what happened. She was awarded compensation for the ophthalmologist's failure to warn her of the remote risk).

Withdrawal of consent

Consent can be withdrawn at any time; however, it is important that the person withdrawing consent informs the person undertaking the procedure.

Capacity to consent

Legal capacity covers mental capacity, intellectual capacity and the capacity of children to give a legally valid consent or refusal to consent to treatment. The legislation and case law in each of the states and territories define 'capacity' to apply to specific situations and make provision for both the identification and legal authority of substitute decision makers. Examples of the relevant legislation include Mental Health

Acts, Guardianship and Administration Acts, childcare and protection legislation and the Transplantation and Anatomy Acts. Generally, 'capacity' requires that the person must be able to absorb and analyse information; weigh up the benefits and risks; communicate a decision; and demonstrate overall comprehension about the matter to which they are providing consent.

Mental health patients The vast majority of adults within the mental health system are 'voluntary' patients and therefore have the same legal rights to consent or refuse to consent to treatment as any other patient within a healthcare facility. Some patients, however, have mental illnesses or disorders of the mind that periodically render them a danger to themselves and/or others; and, for a time, are incapable of seeking appropriate assessment and treatment. For those patients, it may be necessary to invoke the non-voluntary provisions of the mental health legislation. The examination, admission and treatment of non-voluntary patients will be dictated by the mental health legislation in each jurisdiction and may include medical and nursing intervention without the patient's consent.

Intellectually impaired persons Legislation is in place in all states and territories to address the issue of obtaining a legally valid consent to medical and dental treatment from individuals with an intellectual impairment (including intellectual disability, acquired brain injury and dementia). As a general proposition the legislation (ACT: Guardianship and Management of Property Act 1991; NSW: Guardianship Act 1987; NT: Guardianship of Adults Act 2016; Qld: Powers of Attorney Act 1998, Guardianship and Administration Act 2000; SA: Guardianship and Administration Act 1993; Tas: Guardianship and Administration Act 1995; Vic: Guardianship and Administration Act 1986; WA: Guardianship and Administration Act 1990) seeks to identify and empower a substitute decision maker for the period in which the adult is incapable of giving a valid consent to treatment on their own behalf. As an example, a person with a profound intellectual disability that renders them incapable of making a healthcare decision will have a suitable person nominated as a substitute decision maker under the legislation. It is the substitute decision maker who takes responsibility for making the decision to consent, or refuse to consent, to the treatment or procedure. It is of note that in some states and territories the substitute decision maker may also have the legal authority to make decisions about the adult's lifestyle and accommodation.

Children A combination of common law principles and legislation applies when treating children. At common law a child may consent to treatment that is therapeutic, provided they have sufficient mental capacity to understand the nature and consequences of the proposed treatment. The application of this principle requires a balance between the intellectual and emotional maturity of the minor and the complexity and seriousness of the proposed treatment (see *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402, approved by the High Court in the case of *Department of Health and Community Services v JWB and SMB* [1992] HCA 15 'Marion's Case'). Most probably, a child of a quite young age could give a valid consent to a simple procedure that does not involve a great risk of harm. For example, a child who falls over and suffers a minor graze in the school grounds could be expected to have the capacity to consent to the wound being treated. In all other cases, parental or

guardian consent should be obtained. A Family Court authorisation must be sought for consent to carry out an elective procedure that will lead to an intellectually disabled person being made infertile. The parents of a 14-year-old girl who suffered from severe disabilities including mental retardation applied to the Family Court for an order authorising the performance of a hysterectomy and an ovariectomy on her. According to the court the decision to cause a profoundly intellectually incapacitated child to be sterilised should not be within the ordinary parental power to consent but requires Family Court authorisation (see 'Marion's Case' above).

Legislation can change or modify the common law. For example, legislation in New South Wales provides that consent to medical and dental treatment given by a parent or guardian of a minor aged less than 16 years, or by a minor aged 14 years or upwards, is a defence to an action for assault and battery in respect of that treatment. Between the ages of 14 and 16, the consent can be given by a parent or the child, provided the child has sufficient maturity to understand the nature of the treatment and to give a valid consent. Below the age of 14 years, the consent of the parent or guardian is required (except in an emergency to save the life of the child). The definition of medical treatment includes treatment carried out by persons following the orders of a medical practitioner, and this would apply to nurses when they are carrying out a doctor's orders (see section 49 Minors (Property and Contracts) Act 1970 (NSW)).

When a parent or guardian has not given consent, or is refusing to consent to treatment that is for a child's benefit, most states and territories have legislation that enables doctors to perform life-saving treatments on children without parental consent (e.g. section 174 Children and Young Persons (Care and Protection) Act 1998 (NSW)). When a child needs treatment for a condition that is not immediately life threatening, the matter may be referred to the Supreme Court of a state or territory in its *parens patriae* jurisdiction; or the family law courts can make a decision consistent with the best interests of the child where parents or guardians refuse consent to non-urgent treatment for a child; or there is any dispute regarding consent (e.g. blood transfusions: *Women's and Children's Health Network Inc v JC, JC, and KC (By Her Litigation Guardian)* [2012] SASC 104; Hepatitis B injections: *In re H* [2011] QSC 427). Children who are wards of the state or territory have issues relating to consent to medical treatment covered by relevant child welfare legislation in each state or territory.

Dying with dignity Because some terminally ill patients are no longer mentally able to withhold their consent at the time when they might wish to do so, statutory mechanisms have been developed in most states and territories to give legal effect to their wishes after they have ceased to have the capacity. For example, a person may not wish to be resuscitated should they collapse; or have intensive care treatment; or even antibiotics prescribed if they should develop an acute infection.

Different jurisdictions use different terminology for the mechanisms and documentation produced by their legislation. The most commonly used term is some variation on an advance care directive. Both Western Australia (WA) and Queensland (Qld) have developed provisions within existing legislation: WA under the Guardianship and Administration Act 1990 (WA) and Qld under the Powers of Attorney Act 1998 (Qld). Both statutory documents are called Advance Health

Directives. The Australian Capital Territory (ACT) provides for Health Directions under the Medical Treatment (Health Directions) Act 2006 (ACT); the Northern Territory (NT) provides for Advance Personal Plans under the Advance Personal Planning Act 2013 (NT); and South Australia (SA) and Victoria (Vic) provide for Advance Care Directives under the Advance Care Directives Act 2013 (SA) and the Medical Treatment Planning and Decisions Act 2016 (Vic) respectively. Neither New South Wales (NSW) nor Tasmania (Tas) have statutory provisions in place, but both state health departments have policies that create the possibility for patients to make advance care directives and provide forms and advice on how to do so.

Defences

There are a number of defences against an action in assault or battery that are relevant to the provision of healthcare. The first, and most obvious, defence is that the nurse or midwife has obtained a legally valid consent from the person or the person's substitute decision maker. Legislation in some jurisdictions may also permit treatment of patients without their consent. As an example, the mental health legislation (as discussed above) and the Queensland Guardianship and Administration Act 2000 provides for the non-consensual treatment of patients (see also NSW: Guardianship Act 1987; Tas: Guardianship and Administration Act 1995; Vic: Guardianship and Administration Act 1986). The defence of necessity permits a health professional to carry out treatment without consent, provided the treatment is intended to avoid a greater risk of harm to the person. The defence operates in those circumstances when patients are unable to give consent and the treatment is necessary to preserve them from a serious danger to their life. An example would be a patient who has suffered head injuries in a car accident and is unconscious. It would be justified to perform whatever surgery is necessary to save the patient from death or a serious risk to their health.

Finally, the defence of self-defence is applicable in the event that a patient or others assault a healthcare worker in anger. People who are assaulted are legally entitled to defend themselves, but the force used must not exceed what reasonably appears to be necessary to repel the attack.

PATIENT FREEDOM OF MOVEMENT

During the course of clinical practice, a nurse or midwife will encounter people who wish to leave a healthcare service against the advice of health professionals. Unless there is a law that allows for the detention of patients without consent, then people do have the right to leave.

False imprisonment is defined as: 'Unlawfully restraining the liberty of another person' (*R v Banner* [1970] VR 240). The restraint must be total, not merely a partial obstruction of a person's free movement (*Bird v Jones* (1845) 7 QB 742; 115 ER 668). It is also known as 'detention' or 'wrongful imprisonment' (Butt 2004:168).

The tort of false imprisonment compensates a person who has been subjected to an intentional and total restraint of movement without lawful justification. Restraint is either by total confinement or by preventing the person from lawfully leaving the place where they are. The tort can be committed where a patient is too ill to move, or is

unaware of the fact that they were imprisoned by reason that they were in a state of drunkenness or while asleep (see *Meering v Grahame-White Aviation Co Ltd* (1920) 122 LT 44. See also *Hart v Herron and Anor* [1996] NSWSC 176; 226/80 378/80 CL 12781/79). In the latter case, Mr Hart was detained and treated with electroconvulsive therapy (ECT) and deep sleep therapy at a private psychiatric hospital without proof of his consent. He successfully sued the psychiatrist for assault and false imprisonment.

The plaintiff must prove the confinement was total. If the person can leave by some reasonable alternative exit, there is no false imprisonment. Locking a patient in a room with no reasonable avenue of escape, or barring a patient from lawfully leaving a healthcare institution, could amount to false imprisonment in the absence of lawful justification.

Using bed rails, manacles and chemical restraints can also be regarded as false imprisonment if they are used without lawful justification and totally confine the patient. Removing a disabled person's wheelchair, which they need to move about, is another example. It can also amount to false imprisonment if a patient reasonably believes that any attempt to leave a healthcare institution will be prevented by a nurse or midwife, even if there are no physical restraints (psychological restraint). This could occur if a nurse or midwife gave the patient the impression that they would be prevented from leaving if they tried to do so; for example, telling the patient they could not leave until they saw a doctor and signed a release form. However, the patient would have to prove the submission to the nurse or midwife was complete and it was a reasonable response.

Hospitals develop policies requesting patients to see a doctor and to sign a release form in the event that a patient wishes to leave hospital against medical advice. There is no problem if a patient voluntarily agrees to the request. Some doubt exists as to whether hospital staff could detain a patient without consent in order to fulfil the hospital requirements. In the event that a patient leaves without advising staff, or refuses to stay to sign a release form and see a doctor, the patient should not be prevented from leaving and the events should be clearly and contemporaneously documented in the hospital notes.

The fact that a patient wishes to leave hospital against medical advice does not relieve the staff from advising the patient of any deleterious effects a premature departure from hospital could entail, if the patient will remain to accept such advice. Wherever possible, staff should ensure that the patient fully appreciates the risks involved in leaving against medical advice.

Defences

Defences that can be raised against an allegation of false imprisonment include the common law defence of necessity, which permits the restraint of persons who are a danger to themselves or others. However, restraint is not justified if it is merely for the convenience of staff; there must be a real necessity to protect the patient or others. The restraint of a patient attempting to jump off the roof of a hospital, or threatening staff and other patients with violence, would be justified on this basis.

A second defence exists where legislation authorises the detention of persons (e.g.

mental health and public health legislation). A third lawful means of detaining patients is where a court authorises the detention of a person for treatment. Such orders are usually reserved for the detention of children when parents wish to remove a child in need of care from a healthcare institution. Finally, detention without consent is permissible to effect a lawful arrest when a person has committed a crime.

PATIENTS' PROPERTY

During the course of clinical practice, nurses and midwives will be faced with the prospect of taking charge of a patient's valuables, particularly when the patient is to be temporarily away from the ward to undergo surgery or investigations. When a patient's valuables are handed to a hospital for safekeeping, the law of bailment governs the relationship. The law of bailment is a contract and applies when one person (the bailor) delivers goods to another (the bailee) so that they may be used or stored until they are to be delivered back to the bailor.

Bailment may be for reward or gratuitous (free). When bailment is for reward, the bailee will be held liable to compensate for the loss of the goods according to the ordinary rules of negligence; whereas the bailee is only liable if gross negligence is shown in cases of gratuitous bailment. With respect to patients' valuables handed over to a hospital for safekeeping, the hospital is legally regarded as a bailee for reward and therefore has an obligation to exercise reasonable care in securing the safety of the valuables and redeliver the goods in due course.

A hospital can become an involuntary bailee for patients' property. A hospital in New Zealand was held liable to compensate the estate of a deceased woman for a ring that disappeared from a woman's hand at the time of her death (*Southland Hospital Board v Perkins Estate* [1986] 1 NZLR 373). The woman's personal control over her property ended with her death, and the hospital was held to be an involuntary bailee for the ring.

When a patient dies in hospital, any valuable property should be removed and kept in safekeeping to be handed over to the deceased person's legal personal representative. Non-valuable items such as clothing and toiletries can be sent home with a relative or friend. Police usually deal with the property of a person who is brought in deceased on arrival.

Healthcare services develop policies and procedures to fulfil the duty of care to protect a patient's valuables and nursing and midwifery staff should follow these. As a general principle people should be encouraged to leave any unnecessary property at home and/or consent to their families being requested to take unnecessary valuables and property elsewhere. If the patient requests to have their possessions under the care of the health service, then the valuables should be recorded in a document that is signed by the patient. When the patient is unable to sign, the valuables should be recorded by one nurse or midwife and witnessed by another.

The valuables must then be stored in a safe place. For short-term care the valuables may be stored in a locked cupboard at unit level (not the secured cupboard used for the storage of Schedule 4 and Schedule 8 drugs). If the valuables are to be cared for on a long-term basis, they should be stored in a hospital safe. Patients are generally required to sign for the goods upon return to them. In the case of a deceased patient, the person

legally entitled to deal with the patient's property after death would sign for receipt of the valuables.

In the event that the goods are lost, the patient has the onus of proving negligence and the value of the property. Nurses and midwives are not trained in evaluating the quality of valuable goods such as jewellery, and should not attempt to describe such goods as being of any particular kind and value. For example, a sapphire and diamond ring in a gold setting should be described as a ring with blue and clear stones set in a yellow-coloured band, even if the patient states that the stones are a sapphire and diamonds, and the metal is gold.

Where theft of valuables is suspected, the police should be notified. The police can undertake an investigation and lay criminal charges where they reasonably suspect a member of the nursing staff or other person is responsible.

Criminal law

During the course of practice, a nurse or midwife may assault or cause serious bodily harm or death to patients. As well as providing facts that may be the subject of a civil action, such events may result in charges of criminal assault, criminal negligence, manslaughter or, rarely, murder. The prosecutor must prove both *mens rea* (guilty mind) as well as *actus reus* (an unlawful act). The *mens rea* element can be satisfied by proving that the accused committed an unlawful act, either with intent or could have foreseen that someone could suffer harm but nevertheless proceeded to commit the act.

CRIMINAL ASSAULT

Assault can be the subject of a criminal charge as well as a tort. In addition to the elements required to prove civil assault, there must be proof of an intentional forcible or hostile act of the accused or a recklessness as to the outcome of the conduct. If a patient is criminally assaulted (e.g. threatened, punched, grabbed or kicked), the matter must be reported to administration and, most importantly, to the police, who can charge the responsible party with criminal assault. The same legal redress is available to nurses and midwives who are assaulted by others. Conduct that is driven with malice and intended to cause harm, or a reckless indifference to the harm, amounts to criminal assault. Touching a person in the course of diagnosis or treatment without consent may give rise to an action to recover compensation at civil law but is unlikely to be regarded as a criminal assault where the intent is to benefit the patient.

An assault with consent may not be an assault as is the case with most contact sports (e.g. a lawful boxing match). However, if an act is unlawful, it cannot be made lawful because of consent of the victim. Therefore, sexual relations with a minor remains unlawful even if the minor is consenting. Deceit as to the identity of a person or the nature of the act will render consent invalid. The consent of a person to a diagnostic or therapeutic treatment obtained by a person impersonating a nurse, midwife or other health professional is invalid in law. Should a nurse or midwife examine a patient, extending the examination to breasts or sexual organs beyond what is required for a legitimate examination, the nurse or midwife can be found guilty of a sexual assault.

The seriousness of an assault will determine the response of the criminal law. Conduct that goes beyond a threat and involves actual harm may be categorised as a common assault, assault causing actual bodily harm or assault with intent to cause grievous bodily harm. Each offence has particular elements that must be proven beyond reasonable doubt in order to result in a conviction.

Defences

There are a number of defences that may successfully defeat a charge of criminal assault; for example, the defence of self-defence. Self-defence involves the use of force by one person to repel an attack on them. A person may use reasonable force to repel attacks, but must not use more violence than is necessary to repel the attack. The right of self-defence only lasts as long as any danger exists. A nurse or midwife would be entitled to exercise the right of self-defence if attacked by a patient or other person, provided the nurse or midwife believed, on reasonable grounds, that it was necessary to do what they did and used no more force than was necessary to repel the attack. The onus of proving the reasonableness of the self-defence lies with the person relying upon it.

CRIMINAL NEGLIGENCE, MANSLAUGHTER AND MURDER

Nurses and midwives can be charged with criminal negligence where an act causing serious bodily harm or death shows such a high disregard for the life and safety of another, and is so reckless, that it goes beyond a mere matter of compensation at civil law and amounts to a crime. Where the death of a patient results from conduct that would give rise to a charge of criminal negligence it is generally referred to as involuntary manslaughter. The conduct of the nurse or midwife would amount to involuntary manslaughter where the nurse's or midwife's practice, though not intended to bring about the death of the patient, was so grossly negligent it amounted to something no reasonably skilled person would have done. In the case of *R v Pegios* [2008] NSWDC 105, the dentist was charged with manslaughter when it was alleged the patient had died after being negligently overdosed with a sedative. The court held that the Crown needed to prove beyond reasonable doubt that:

1. 'the accused owed a duty of care to the deceased;

2. by his act or omission, the accused negligently breached that duty of care;

3. the accused's negligent act/omission caused the deceased's death; and

4. considering the extent by which the accused's act fell short of a reasonable standard of care and the associated level of risk of death, the degree of the accused's negligence was so "gross" that it amounted to a crime'.

(R V PEGIOS [2008] NSWDC 105 AT PARA 11)

It is the lack of intention (*mens rea*) that distinguishes the lesser charge of manslaughter from murder. In the case of *Timbu Kolian v R* [1968] HCA 66; (1968) 119 CLR 47 at para 6 Justice Windeyer stated that it would be '… correct to say that by the common law today an unintended, wholly unexpected and unlikely killing is manslaughter if, but only if, it be the result of some act which is both unlawful and in the circumstances dangerous, or is the result of some conduct amounting to reckless negligence'.

Manslaughter and murder come under what is generally referred to as 'homicide'. A charge of murder could be laid where the nurse or midwife intended the patient to die or was grossly reckless as to whether the patient died. A nurse or midwife who assists or counsels another to suicide can be charged with aiding and abetting a suicide or attempted suicide. Criminal charges may result from a referral by a coroner to the relevant Crown law authorities following a coronial inquiry into the death of a patient.

In addition to the requirement of an intention to kill or cause grievous bodily harm or recklessness there is the necessity to prove causation. The prosecutor must prove that the act caused the death of the victim. This is not always easy to do. For example, if a person suffers brain damage as a result of an act (e.g. negligently given an overdose of a drug) and is placed on a life support system, then it cannot be said that the act has caused the death of the person. If the life support system is disconnected because the victim is brain dead, the question arises as to whether the defendant caused the death of the victim. When the initial act was the operative factor in causing the brain damage, then turning off the life support system does not break the chain of causation and a conviction for murder or manslaughter can stand. For example, a victim is brought to hospital as a result of a bashing causing brain damage. They are put on life support, which is appropriately removed. It is the act causing the brain damage that causes the death, not the removal of the life support (see *R v Malcherek* [1981] 2 All ER 422). But if the patient dies as a result of some other event, unrelated to the brain damage, then it cannot be said that the act causing brain damage was the cause of the death. In the latter case, a charge of murder or manslaughter could not be made out. A charge of criminal negligence may still be made out.

Vicarious liability

When a nurse's or midwife's act or omission has caused harm to a patient and the patient has successfully sued to recover compensation for that harm from the practitioner, the question arises as to who is responsible for providing the compensation. Under the law of vicarious liability, an employer can be held responsible for the acts of its employees carried out in the course of their employment. The employer is liable without any blame or fault. In some states (including NSW) the employer cannot chase the employee for damages paid out.

An employer's responsibility is limited to an employee's acts performed during the 'course of employment'. However, this term is fairly broad and encompasses all acts, authorised or not, which are reasonably within the scope of the employee's duties. Therefore, a healthcare employer can be held legally responsible to compensate an injured patient whose injuries resulted from an employee's negligence. It is only when a

nurse's or midwife's actions are so far removed from anything that can reasonably be held to be part of a nurse's or midwife's role that an employer will escape responsibility. A nurse's or midwife's failure to follow guidelines in a procedure manual would generally not be enough to excuse the employer unless there was a gross departure from standards.

An employer has a duty to employ competent staff. If a staff member is incompetent, then the employer is at fault even if all possible steps were taken to employ competent staff.

Vicarious liability merely means that the healthcare employer will generally be the party that will be held responsible for compensating a successful plaintiff and does not negate the nurse's or midwife's personal liability. The nurse or midwife may be joined as a co-defendant. Responsibility under vicarious liability applies with respect to civil wrongs, but normally does not apply to criminal acts. Therefore, a health service may be found vicariously liable for a nurse or midwife who commits a civil assault by giving an injection without consent, but not if the nurse or midwife angrily punched a patient.

A nurse practitioner or a midwife in private practice is solely liable for harm caused by that practitioner's practice. An independent practitioner in turn becomes vicariously liable for harm caused by a person employed by the practitioner to assist in the practice. It is essential that healthcare services and practitioners have secured professional indemnity insurance cover in the event of successful litigation by a patient. This cover, which is now required by the NMBA as part of the registration standards, should be sufficient to pay the highest amount that could be awarded from time to time.

Even when an employer cannot be found to be vicariously liable because a person committing a wrong is not an employee, the courts have been prepared to find that an organisation such as a hospital has a personal duty of care towards patients and others that is non-delegable. A hospital can be found negligent for harm caused to a patient by reason of its personal liability, when the act or omission of a visiting medical officer caused the alleged harm. When a hospital's policies and procedures could expose a patient to an unreasonable risk of harm, a duty arises to avoid that harm.

Patient records

The recording of patient and client information is, across all states and territories, continuing in a process of transition from hard copy to electronic version. Nonetheless, the documentation of patient care, in whatever format, is fundamental to good patient care. This proposition is supported in the guidelines and codes published by the respective professional regulatory authorities (see the International Council of Nurses 2012; the International Confederation of Midwives 2014; the Code of conduct for midwives 2018a; Nursing and Midwifery Board of Australia 2018b; and government policies and directives (e.g. see New South Wales Department of Health 2012). Patient records are legal documents and, therefore, it is important to keep accurate and complete records of all treatment and care administered to patients. The documents record the progress of patients admitted to healthcare services for the period of time that they are receiving care. Accurate and complete documentation can provide a good defence for a nurse or midwife who is faced with an action by a patient when the

patient's record discloses that appropriate, timely and reasonable nursing or midwifery care was delivered.

Even when appropriate treatment may have been administered, failure to keep accurate, concise, objective and contemporaneous patient records can lead to a finding of liability on the part of a nurse. Failure to record treatment may be accepted as evidence that such treatment was not in fact given. Overall failure to keep complete and adequate records can be regarded as a negligent omission, since a reasonable nurse and midwife would be expected to keep all patient record notes in order and up to date. It is reasonably foreseeable that a patient may suffer harm from failure to record a treatment given (e.g. a patient may be given two doses of a drug because a first dose was not recorded).

Although it is important that a patient's records be complete and up to date, a nurse or midwife should not write more than is necessary as quality not quantity is the key. In circumstances where a nurse or midwife offers treatment or advice, and a patient refuses, it is prudent to include a notation to this effect in the patient record.

Patient records should be objectively written, and those responsible for writing records should avoid making value judgements. 'Patient has a headache' is a subjective statement and should be recorded as 'patient complaining of headache'. A description of the nature of the headache, the nursing action taken and the outcome of that action should follow this statement.

Records should be as near as possible contemporaneous with the event for both quality ongoing care and if they are to be accepted as reliable evidence in a court action. Delays in recording make the record less reliable as a true description of an event. In fact, a record made days after an event can be made to look as though it was an afterthought. Interlineations and notes made in margins should also be avoided, as they can suggest that information has been added to a record at a later date. It is for this reason that nurses and midwives, who are still recording patient information in hard copy, are advised not to leave lines between individual reports.

Errors in recording should not be completely erased since this can appear suspicious in the event that a patient is suing on the basis of delivery of healthcare. Mistakes should be identified as such, in a manner that enables others to be able to read what was initially written. A notation that the recording was made in error, signed by the person making the error, should be added to the record.

A mistake in-text is to be treated in the following way:

> *'[a]n accepted method of correction is to draw a line through the incorrect entry or 'strikethrough' text in electronic records; document "written in error", followed by the author's printed name, signature, designation and date / time of correction'.*
>
> *(NSW DEPARTMENT OF HEALTH, 2012:6)*

If the error is made on an electronic record a similar principle should apply to ensure the mistake and the correction is obvious, for example:

> *'For electronic records the history of audited changes must be retained and the replacement*

note linked to the note flagged as "written in error". This provides the viewer with both the erroneous record and the corrected record'.

(NSW DEPARTMENT OF HEALTH, 2012:6)

Nurses and midwives should be aware that personal information given by patients in the course of administering care is to be kept confidential. The legal obligations of confidentiality and privacy arise when creating, managing or using healthcare records. However, these two areas deal with matters that are broader than healthcare records, as they go to relationships, trust and having adequate information to provide safe, competent care to patients while ensuring their dignity and integrity is maintained. Although these two concepts are often used interchangeably, they have in fact quite distinct meanings and should be differentiated. 'Confidentiality refers specifically to restrictions upon private information revealed in confidence where there is an explicit or implicit assumption that the information shared will not be disclosed to others' (Kerridge et al 2013:298), whereas 'Privacy refers to one's ownership of one's body or information about one's self' (Kerridge et al 2013:298).

Patients are entitled to expect that nurses and midwives will maintain a high degree of confidentiality and protect their privacy. Should a nurse or midwife breach a patient's confidentiality, the patient may be able to sue in defamation for unlawful disclosure if their reputation has been harmed; in negligence if they suffer foreseeable loss or damage; or in breach of contract. Australian Commonwealth and state privacy Acts address complaints of breaches of privacy. In 2014 the Australian Privacy Principles (APPs) were introduced to regulate the handling of 'personal information'. Personal information includes a person's health information, which is classed as 'sensitive information' (section 6 Privacy Act 1988 (Cth)).

Access to a record can be granted to third parties with the consent of the patient. For all other purposes, access should be denied to all others except other health professionals treating the patient on a 'need to know' basis (i.e. those who have a genuine need to access the information in order to provide adequate care). Confidentiality may be legally breached by virtue of legal process (discovery and subpoenas), statutory authority, necessity and the criminal law.

Legislation generally provides that patients have a right of access to their medical records. The Australian Government and various state and territory governments have enacted freedom of information, or right to information, legislation that gives people a right to have access to various documents, including personal documents held by public authorities. These Acts also provide for requesting that the documents be amended if there is any material that is false or misleading. In 2002, the New South Wales Government introduced the Health Records and Information Privacy Act 2002 (NSW), giving patients the right to access their healthcare records held by private practitioners. Exceptions to disclosure can be found embodied in the various Acts.

As a general policy, patients should be given access to their records as freely as possible. A healthcare practitioner should be available when a patient is accessing their record in order to assist the patient in understanding the nature of what has been written and why it was written. Patients may be temporarily prevented from accessing

their records in certain circumstances. For example, as part of a court order, or if seeing the record might place the patient or others at risk of harm. However, the assumption is that a patient has the right to have access to their records.

The Australian Government has enacted the Personally Controlled Electronic Records Act 2012 (now known as the My Health Records Act 2012) to set up a National e-Health records system. The Act provides for healthcare providers (section 42) and consumers (patients) to register (section 39). It is a voluntary process referred to as an 'opt-in' system. It is a condition of registration of a healthcare provider organisation that the organisation does not refuse to provide healthcare to a consumer or otherwise discriminate against a consumer in relation to the provision of healthcare because the consumer is not registered (section 46).

For those patients who register, the system is planned to enable easy access to information about their medical history, including test results and medications online. The system also enables patients to attend for treatment anywhere within Australia and to consent to health professionals accessing their relevant history. They will not have to remember every detail of their health history each time they consult a different practitioner or use a healthcare service. Patients will also be able to control which health professionals can view their records or add to their files and what is stored on them.

Although patient information is protected and there are privacy protection principles in place, the Act provides that there is mandatory disclosure for coroners' matters. Disclosure to other courts or tribunals is with the consumer's consent. For the purposes of law enforcement, disclosure is when it is reasonably necessary. However, adoption has been relatively slow and caused concerns to some about potential privacy breaches.

Regulation of drugs

Each state and territory has specific legislation that regulates the manufacture, prescribing, supply, possession and use of medicines, drugs, poisons and other controlled substances within its jurisdiction (e.g. ACT: Medicines, Poisons and Therapeutic Goods Act 2008; NSW: Poisons and Therapeutic Goods Act 1966; NT: Medicines, Poisons and Therapeutic Goods Act 2012; Qld: Health Act 1937; SA: Controlled Substances Act 1984; Tas: Poisons Act 1971; Vic: Drugs, Poisons and Controlled Substances Act 1981; WA: Medicines and Poisons Act 2014). The rules and regulations regarding the drugs that nurses and midwives routinely administer to patients can be found within each relevant state or territory Act, associated Acts and any Regulations to the Act. While an Act may specify in broad terms the rules regarding the control of drugs and poisons, regulations formulated under the power of the Act set out in greater detail the specifics of the obligations of individuals under the Act.

Drugs and poisons are usually classified in Schedules according to the manner in which they may be supplied (e.g. Schedule 4 and Schedule 8 drugs are particularly pertinent to midwives and nurses as the storage, supply and administration of these are tightly controlled as they are recognised as drugs of addiction). Changes in the Schedules take place when new drugs come into use or there are changes in the manner in which a particular drug may be supplied. For example, a drug that formerly required a doctor's prescription may be moved to a Schedule that permits the drug to be

purchased over the counter from a chemist.

All nurses and midwives should become familiar with the relevant Act and any regulations operating in the state or territory in which they work.

Regulation of midwifery and nursing practice

The provision of healthcare services in Australia is delivered by both regulated and unregulated workers and professionals. Unregulated workers are not registered with a professional regulatory authority and do not require a licence to work. Examples of unregulated workers would include assistants in nursing and personal care attendants. Regulated health professionals, such as nurses, midwives, doctors and pharmacists, are registered by regulatory authorities who license the individual practitioner to practise in their particular discipline. In Australia, since 2010, specified disciplines of health professionals are registered to practise under the National Registration and Accreditation Scheme (the 'National Scheme' or 'NRAS') facilitated by the Health Practitioner Regulation National Law Act 2009 (the 'National Law'). The National Law was enacted in each of the states and territories with New South Wales (Health Practitioner National Law (NSW) No 86a) and Queensland (Health Ombudsman Act 2013) retaining a co-regulatory system. The National Law provisions apply to practitioners within the disciplines identified, and also to students undertaking study in those disciplines. As a general overview, the co-regulatory systems in New South Wales and Queensland operate so as to leave registration of individual practitioners and accreditation of education providers and programs with the National Boards and Accreditation Councils and Committees; and legislatively retain matters addressing health, conduct and performance of the registered health practitioners to be dealt with by the respective state-based entities of the Health Care Complaints Commission in New South Wales and the Office of the Health Ombudsman in Queensland. This is discussed further below.

Under Australian law, the object of national registration is for the protection of the public by ensuring only suitably trained and qualified health practitioners can be registered to practise and to facilitate workforce mobility across Australia; the provision of high-quality education and training of health practitioners; rigorous and responsive assessment of overseas-trained practitioners; access to services provided by health practitioners in accordance with the public interest; and to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and innovation in the education of, and service delivery by, health practitioners (section 3 National Law).

The Australian Health Practitioner Regulatory Agency (now known primarily by the acronym AHPRA) is the national body responsible for the regulation, national registration and accreditation of health practitioners and the registration of students. AHPRA supports 14 national health practitioner boards that are responsible for regulating each profession. A National Board can establish a state or territory board to enable it to exercise its functions more effectively at a jurisdictional level. The primary role of the National Boards is the protection of the public and to set standards and policies for the professions. With respect to nurses and midwives in Australia, this is the

Nursing and Midwifery Board of Australia (NMBA).

National Boards must develop registration standards for the health professions. These include standards for professional indemnity insurance, criminal history checks, continuing professional development (CPD), English language skills and recency of practice (section 38 Health Practitioner Regulation National Law Act 2009).

As noted above, it is in this area of law and regulation that most matters relating to nurses and midwives arise as complaints or notifications about their health, performance or conduct. While nurses and midwives do have dealings with the civil and criminal courts and the coroners courts, the predominant issues that arise about nurses and midwives relate to breaches of the codes of conduct and ethics; breaches of the professional practice standards (NMBA 2020b) and registration standards (NMBA 2017); and these are dealt with under the National Law through AHPRA, the NMBA, the Health Care Complaints Commission in New South Wales, the Health Ombudsman in Queensland; and if further action is required: a Performance and Professional Standards Panel, a Health Panel or a Tribunal hearing.

In all states and territories other than New South Wales and Queensland, AHPRA, on behalf of the boards, manages investigations into the health, performance or professional conduct of registered health practitioners in conjunction with relevant health complaints entities in the states and territories.

Under the National Law, categories of registration are general, specialist, provisional, limited, non-practising or student. AHPRA is responsible for maintaining and publishing registers of practitioners and important information regarding each practitioner's registration; for example, conditions on registration. Conditions may be public or private. Public conditions are those which relate directly to the workplace and are made available to the public on the AHPRA website. Health-related conditions are not made available to the public. A registered health practitioner who has conditions on registration who knowingly or recklessly claims or holds themselves to be registered without conditions, may become the subject of a health, conduct or performance action (section 120).

In Australia, it is an offence, punishable by a fine or imprisonment, for a person to take or use a prescribed title that could reasonably be expected to induce a belief the person is registered under the National Law in the profession unless the person is so registered. Nor can a person who is not a registered health professional knowingly or recklessly take or use protected titles (sections 113–119).

In order to be eligible for general registration in a health profession, an applicant must be qualified for general registration in the health profession and have successfully completed a period of supervised practice or examination or assessment required by an approved registration standard for the health profession to assess their ability to competently and safely practise the profession, and that they are a suitable person to hold general registration (section 52). The qualifications required for general registration are that the applicant must hold an approved qualification for the health profession or one that is substantially equivalent, or gained under a corresponding prior Act (section 53). Legal requirements for specialist registration are found in sections 57–61; provisional registration in sections 62–64; limited registration in sections 65–71; and

non-practising registration in sections 73–76. In Australia, the National Board has the power to check an applicant's proof of identity (section 78) and to check their criminal history (section 79). The National Board must give written notice to an applicant if it is proposing to refuse registration or to register an applicant subject to a condition to allow the applicant to make written or verbal submissions (section 81).

In Australia, section 55 of the National Law empowers the National Board to decide if a person is unsuitable to hold registration as a health professional. Issues the Board may consider include: an impairment that would 'detrimentally affect the individual's capacity to practise the profession'; the particulars of the criminal history; competency to speak or otherwise communicate in English; current suspension or cancellation of registration in another jurisdiction; or a failure to meet other requirements about suitability to be registered or to competently and safely practise the profession.

The relevant National Board maintains a register of students who are undertaking an approved program of study, or part of an approved program (section 89). Unlike applications for registration once qualified, students do not have to apply for student registration. It is up to accredited education providers to provide this information to the Board. The Board may ask education providers for a list of persons undertaking an approved program of study (section 88). Education providers must provide lists of persons who are enrolled in an approved program of study who are undertaking clinical training in a health profession (section 91).

A National Board may endorse the registration of a registered health practitioner to administer, obtain, possess, prescribe, sell, supply or use a class of scheduled medicines (section 94). Some midwives are endorsed to prescribe scheduled medicines; and some registered nurses working in rural and remote practice are endorsed to supply scheduled medicines; but only with additional qualifications and specific expertise.

The NMBA can also endorse nurse practitioners (section 95). The provision for the endorsement of midwife practitioners (section 96) has not been enacted in Australia at this time. Other endorsements which may be granted are for acupuncture (section 97) or other approved areas of practice (section 98).

In Australia, registered health practitioners must apply annually for renewal of registration or endorsement if they wish to continue to practise. The application must be made no later than one month after the practitioner's period of registration ends (section 107). In addition to re-applying for registration annually and paying a fee, all practising registered practitioners are now obliged to undertake CPD for each profession they wish to remain registered for (section 128) and be able to demonstrate recency of practice.

For the nursing and midwifery professions, midwives and nurses must be able to demonstrate that they have undertaken at least 20 hours continuing professional development annually. This must be documented and verifiable should the nurse or midwife be audited. The requirement for recency of practice is that the nurse or midwife has practised their profession for a period equivalent to a minimum of three months full time within the past five years. Practising includes clinical and non-clinical roles relevant to the delivery of nursing and midwifery services. Examples of non-clinical roles are management, regulatory, education, policy, research and industrial

roles (NMBA 2020a). Nurses who elect to have non-practising registration are not required to undertake continuing professional development. They cannot, however, practise nursing (section 75).

In the annual declaration, nurses and midwives must also declare among other things that they do not have an impairment and that they have not practised the health profession during the preceding year without appropriate indemnity insurance (section 109). Other requirements include the disclosure of criminal charges and convictions, or disciplinary actions taken with respect to their profession in another jurisdiction (section 130).

Unsuccessful applicants for renewal can make submissions regarding a Board's proposal to refuse the application for renewal of registration (section 111).

Also, registered practitioners can surrender their registration by written notice to the National Board (section 137).

As previously stated, New South Wales elected to introduce a co-regulatory model. Registration of health practitioners was transferred to a national body whereas conduct, competence and professional performance of nurses in New South Wales remains a state matter. The Health Practitioner Regulation National Law (NSW) No 86a amends the National Law to provide for a Health Professionals Council Authority (HPCA) to deal with complaints about registered health practitioners. There are individual councils for each of the health professions in New South Wales. The Nursing and Midwifery Council of New South Wales (NMC) is responsible for handling complaints regarding the conduct, competence and professional performance of nurses and midwives employed in New South Wales. Matters relating to a nurse's or midwife's registration are handled by the NMBA. The NMBA is the body to review conditions should a nurse with conditions on registration change their principal place of residence or predominant place of practice from New South Wales to another state or territory. A review of conditions and undertakings may be made to the National Board (section 125) and in New South Wales to the Nursing and Midwifery Council (sections 127A and 127AA). The Council consults with the Health Care Complaints Commission (HCCC) regarding taking action with respect to complaints.

The legislation provides for a review or right of appeal against a decision of a board, council or disciplinary body to an appropriate judicial body.

The Health Ombudsman Act 2013 (Qld) also establishes Queensland as a co-regulatory jurisdiction for the purpose of dealing with complaints in relation to regulated health professionals. The Act empowers the Health Ombudsman to manage all health service complaints. AHPRA and the Nursing and Midwifery Board are restricted to dealing only with disciplinary matters referred by the Health Ombudsman with the matters to be referred limited to minor and less serious matters. Section 14(6) of the Health Ombudsman Act 2013 (Qld) confirms that the Health Ombudsman may refer a complaint to AHPRA except for professional misconduct and certain other serious matters.

It is of note that the jurisdiction of the Health Ombudsman extends to both regulated and unregulated health professionals and workers.

The above discussion provides an overview of some of the provisions of the National

Law. It is not definitive and nurses and midwives should obtain a copy of the Act in the jurisdiction in which they practise in order to become fully aware of the provisions as they apply to the state or territory where they are practising.

In addition to gaining knowledge of the legislative provisions governing nursing and midwifery practice, all nurses and midwives should acquaint themselves with the various nationally agreed codes of conduct and ethics, practice standards, frameworks and guidelines for professional practice governing the practice of nursing and midwifery. For example, the Codes of Professional Conduct, and Codes of Ethics for Registered Nurses, Midwives, Enrolled Nurses and Nurse Practitioners in Australia and the National Standards for Practice (NMBA Professional Codes and Guidelines —NMBA 2014, 2016a, 2016b, 2018c).

The role and responsibilities of the two organisations, the Nursing Council of New Zealand and the Midwifery Council of New Zealand, are set out in the Health Practitioners Competence Assurance Act 2003. The primary role of the councils is to protect the public through the regulation of nurses and midwives. The councils are responsible for the registration of nurses and midwives and empowered to produce standards, codes and guidelines. The councils are also responsible for investigating complaints regarding nurses and midwives and the imposition of sanctions such as conditions on registration. As in Queensland and New South Wales, the New Zealand councils have a co-regulatory role with the Health and Disability Commissioner under the Health and Disability Act 1994 (New Zealand).

The Trans-Tasman Mutual Recognition Act 1997 (Cth) mutually recognises the registration of professionals registered in New Zealand and Australia. The Act also permits the exchange of information regarding disciplinary action taken with respect to a nurse or midwife or conditions which have been placed on a practitioner's registration.

Complaints and notifications

During the course of their nursing and midwifery practice, nurses and midwives may observe behaviour, conduct or situations they believe to be inappropriate or wrong, such that they feel obliged to report another professional for their actions. Reporting issues of unsatisfactory professional conduct or unethical behaviour through the proper channels is important in maintaining public confidence in the professions and maintenance of standards.

Notifications or complaints about nurses and midwives generally fall into three categories:

1 PERFORMANCE

Performance assessment under section 5 of the National Law 'means an assessment of the knowledge, skill or judgment possessed, or care exercised by, a registered health practitioner in the practice of the health profession in which the practitioner is registered'. So performance can be defined as 'the knowledge, skill or judgment possessed, or care exercised by, a registered health practitioner in the practice of the

health profession in which the practitioner is registered'. Knowledge, skill and judgement are relatively straightforward, and are usually assessed by peers, in terms of the level of performance expected.

Under section 5 of the National Law, 'unsatisfactory professional performance of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience'.

However, care is slightly more complex as it has been regarded by the tribunals as possessing two different elements: care as caution and care as compassion. Where a nurse or midwife demonstrates a lack of compassion, this is often dealt with quite severely (Chiarella & Adrian 2010).

2 PROFESSIONAL CONDUCT

Unprofessional conduct of a nurse or midwife means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers (section 5 National Law).

Professional misconduct of a registered health practitioner is the more serious of the two categories and relates to unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience. Complaints that are substantiated can result in the suspension or cancellation of the practitioner's registration (section 5 National Law).

Conduct issues are generally related to behavioural acts or omissions. Following investigation of a complaint, disciplinary action may be taken by a professional standards committee or tribunal, depending on the seriousness of the complaint (AHPRA and the National Boards 2020a, b).

3 HEALTH

Complaints about health matters concerning nurses and midwives relate to physical or cognitive impairment, substance abuse and/or mental illness. Health (impairment) is also defined under section 5 of the National Law as 'physical or mental impairment, disability, condition or disorder (including substance abuse or dependence), that detrimentally affects or is likely to detrimentally affect' a registered health practitioner's capacity to safely practise the profession or a student's capacity to undertake clinical training. A non-disciplinary Impaired Registrants Panel (IRP) may be established to assess the physical or mental impairment of the nurse and determine a course of action. This may result in assisting impaired nurses and midwives to manage their condition while they remain employed or there may be a recommendation to make their registration conditional; for example, suspension of practice (AHPRA and National Boards 2019).

MANDATORY NOTIFICATIONS

In Australia, the National Law now requires mandatory notification of notifiable conduct by registered health practitioners and by employers. Notifiable conduct includes intoxication by alcohol or drugs while practising the profession; sexual misconduct in connection with their profession; having an impairment that places the public at substantial risk of harm; or significant departures from accepted professional standards that places the public at risk of harm (section 140). Impairment is defined to mean when a person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect a health practitioner's capacity to practise their profession, or a student's capacity to undertake clinical training (section 5 – Definitions). Registered health practitioners, in the course of practising their profession, must report other health practitioners whom they reasonably believe have behaved in a way that constitutes notifiable conduct, or students who have an impairment that may place the public at substantial risk of harm while undertaking clinical training (section 141). An employer of a registered health practitioner must notify AHPRA when they reasonably believe that the health practitioner has behaved in a way that constitutes notifiable conduct (section 142). AHPRA can report failures of employers to report notifiable conduct to the Minister. Education providers must notify AHPRA if a student has an impairment which may place the public at risk while undertaking clinical training (section 143).

AHPRA and the National Boards have recently developed updated 'Guidelines: Mandatory notifications about registered health practitioners' (to have effect from March 2020) (NMBA 2020c).

WHEN COMPLAINTS CAN BE MADE AND WHO BY

An entity (section 5) may make a complaint to AHPRA regarding a registered health practitioner. This includes members of the public, patients, former patients and their relatives. In New South Wales a complaint may be lodged with the Health Professional Councils Authority—the Health Care Complaints Commission who can investigate the matter. In Queensland, as stated above, complaints may be lodged with the Health Ombudsman.

It should be noted that where complaints are made in good faith, the legislation provides that complainants are protected from civil, criminal and administrative liability; the complaint is not a breach of professional etiquette or ethics; nor does it constitute a departure from accepted standards of professional conduct; and no liability for defamation is incurred (section 237).

Grounds for voluntary notifications or complaints that may be made against a registered health practitioner include a criminal conviction or criminal finding, unsatisfactory professional performance, unprofessional conduct or professional misconduct, lack of competence, impairment and/or that the practitioner is not a suitable person (section 144). The fact that a matter complained of has occurred in the personal life of the nurse or midwife does not exclude it from giving rise to disciplinary proceedings to determine whether the behaviour is such that the nurse or midwife is not a fit and proper person to practise nursing or midwifery. For example, information

that a registered nurse or midwife has been convicted of downloading child pornography will be referred and can lead to a disciplinary hearing with the prospect that disciplinary action will be taken and that the nurse's or midwife's name may be removed from the register.

One issue which can give rise to a complaint is when a midwife or nurse enters into a financial, personal and/or sexual relationship with a patient or former patient. The fact that the nurse/midwife–patient relationship has ceased does not legitimise the relationship if the circumstances were such that the profession regards the relationship as unethical. This is particularly so when the nurse or midwife has become privy to a great deal of sensitive personal information regarding the patient's past and present life and health issues. Such matters are regarded as 'boundary crossings' or 'boundary violations' depending on the extent of the conduct. Whether or not such a relationship falls within prohibited behaviour will be decided on its facts. Nurses and midwives are well advised to seek advice regarding such actual or potential relationships, as it could lead to disciplinary action.

Similarly, midwives or nurses should not accept valuable gifts from patients. The midwife/nurse–patient relationship is such that a court may determine that there was 'undue influence', which brought about the giving of the gift. In matters involving health practitioners and patients, as in other dependent relationships, the courts consider that there is an imbalance of power. As such there is a presumption that 'undue influence' is an operative factor in the giving of a valuable gift. In such cases the recipient of the gift has the onus of proving to the court (rebutting the presumption) that the gift did not flow from undue influence. Even if such an issue is not raised in a court of law, the receipt of a valuable gift from a patient may find the nurse or midwife facing disciplinary proceedings.

The decisions of the courts and tribunals in each state and territory dealing with nursing and midwifery matters are excellent sources of real-life case studies about complaints such as these, and the NMBA publishes case studies that provide guidance about the application of the Code of Conduct for nurses and the Code of Conduct for midwives (NMBA 2018a, b).

Nurses and midwives making complaints

Should a nurse or midwife choose to make a complaint to the administration of the organisation where they work, they must do so confidentially and restrict their complaint or report to senior authorities. In such cases, nurses and midwives should not take it upon themselves to discuss the issue with colleagues as this may lead them to being sued for defamation. Reports must be made in 'good faith' to protect nurses and midwives from liability (section 237 National Law).

Defamation Acts in the various states and territories are now uniform and the same provisions apply across all states and territories. The person complaining of being defamed must prove that what was said or written was capable of being defamatory of them, and that their reputation has been harmed. There are a number of defences available to a defendant in defamation proceedings, including 'qualified privilege'. This defence applies where the recipient has an interest or apparent interest in having

information on some subject, the matter is published to them in the course of giving them information on that subject, and the defendant's conduct in publishing that information is reasonable. The information must be substantially true. Thus, it could be argued that a nurse or midwife who passes on potentially defamatory material to the authorities in adherence to the above specifications would be able to avail themselves of this defence. It should be noted that the defence of qualified privilege is defeated if motivated by malice.

Nurses and midwives who feel that their complaints are not being handled appropriately may take it upon themselves to go outside the usual channels available to them, thus becoming what is known as 'whistleblowers'. Legislation protecting whistleblowers is generally unsatisfactory in its scope and the way in which it protects whistleblowers. Legislation has been introduced largely to protect employees who disclose information about corrupt behaviour in the public sector. Nevertheless, employees who disclose such information may face the risk of being considered as breaching their duty of confidentiality to their employer and suffer general censure or legal consequences from that employer.

Certainly, it is accepted that reporting corrupt or risky behaviour of another health practitioner through the proper channels is a matter of public interest. Nurses and midwives who consider taking this path would need to take reasonable steps to satisfy themselves that what they are wishing to report is substantially true and a matter of public interest, and that they adhere to appropriate steps when doing so to protect themselves and to ensure that no unjustifiable complaints are made.

CONCLUSION

Knowledge of the law and its application to nursing and midwifery practice has become a necessary component of a midwife and nurse's knowledge base. Nurses and midwives must be aware of and respect the legal rights of patients and the corresponding obligations of nurses and midwives in nursing and midwifery care. Through an interest and knowledge of the law, a nurse and midwife can most effectively act as an advocate of patients by being involved in, and charged with, the responsibility of formulating policies for the delivery of health and midwifery care.

Failure to appreciate the legal rights of patients can lead a nurse or midwife to face a legal action mounted by a patient or some disciplinary action taken by a professional regulatory authority. Acknowledgement of, and adherence to, the legal rights of patients also goes to the maintenance of quality nursing and midwifery care and the respect to be accorded to the profession. It is a professional obligation of all nurses and midwives to acquaint themselves with current legal issues touching upon the profession, and to do so by remaining up to date with their legal knowledge.

The discussion of the law and legal issues in this chapter is necessarily brief. This basic introduction does not purport to give legal advice. Should a nurse or midwife require industrial or legal assistance they should seek advice from their industrial organisation or a legal practitioner at the time that an adverse event or other area for potential action arises.

Reviewers

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REFLECTIVE QUESTIONS

1. Identify the legislation in your state or territory that impacts on nursing and midwifery practice. How would you ensure the legislative obligations were incorporated into your practice?
2. Consider the codes of conduct and ethics and the standards of practice that apply to nurses and midwives in Australia. To what extent do you consider these documents adequately provide for the complexities of nursing and midwifery practice?
3. Consider how you would ensure you had a legally valid consent to treatment from: a child, an adult with a significant acquired brain injury and a person regulated as a non-voluntary patient under the mental health legislation.
4. Identify the basis upon which a complaint about a health practitioner may be lodged with the relevant authority and the possible outcomes that may result from the

conduct.

5. Contact your local Magistrates Court and enquire about attending a Coroner's Inquest.

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CHAPTER 10: POWER AND POLITICS IN THE PRACTICE OF NURSING

Stacey Wilson and Katheryn Butters

KEY WORDS

advocacy; equity; power; politics; social justice; speaking up for safe practice

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand the nature of power and politics;
- understand the way in which nurses possess power individually and collectively;
- understand advocacy and agency and how it relates to power and nursing;
- understand the relevance of social justice and equity to nursing;
- appreciate the complexities of speaking up for safe practice and whistleblowing.

INTRODUCTION

In this chapter the concept of power is explored along with the political and structural issues that create unjust health systems to privilege outcomes for some at the expense of others. The need for nurses to claim and utilise political and collective professional power to influence and improve issues of social justice, and support equity of outcomes for people, will be discussed. Finally, the role of nursing in influence and agency will be considered to support nurses to claim their legitimate power to speak up for safe practice and advocate for people's rights in a socially just and morally sound way.

Nursing and politics

Politics, in the broadest sense of the word, is part of all nurses' lives, especially in the large institutions within which many nurses work. It is therefore important to think about power and politics. At the very least, nurses need to understand that the health sector is a politicised environment at micro and macro levels, and that it is not an apolitical or neutral site. Health, healthcare and workforce are dependent on the socioeconomic and political systems that guide the distribution of resources within a society (Gunn et al 2019). Politics plays a central role in determining health and development outcomes globally, and underpins health governance, resource allocation, power and the ideology, values and expectations of countries and citizens (Kickbusch 2015). Rafferty (2017) proposes that despite being the largest regulated workforce, with degree-level entry to practise, prescribing rights, advanced scopes, leading and managing new models of healthcare and health practices, nursing has a history of limited voice in the development of policy making and political influence. In the highly complex financially rationed health environments in which nursing is located, nurses are often a 'soft target' for savings. This cost cutting in relation to nursing has resulted in strategic failures in workforce planning, investment, remuneration and evidence-based policy making for nursing, the consequences of which can be seen in nurse retention, staffing levels, workload, patient/client ratios and workplace conditions, which have flow-on effects of negative patient/client outcomes (Rafferty 2017).

In the UK, despite an ageing population and policy direction to provide more community care, the number of district nurses has decreased (Mabin et al 2016). In Aotearoa/New Zealand, despite national nursing strategy to support the education and development of an increased Māori nursing workforce, only a very small percentage of Māori are employed, which is not comparable to the percentage of Māori in the total population. The number of internationally educated nurses working in New Zealand is more than triple that of Indigenous nurses (New Zealand Nurses Association 2018). While nursing shortages are predicted to be over 100,000 by 2025 in Australia (Health Workforce Australia 2012), in Queensland the number of unemployed new graduate nurses has increased with reduced state health expenditure seen as a contributing factor (Gilmour et al 2016).

If success in politics is judged by control over resources, nurses historically have been

unsuccessful in the political arena when judged by factors such as pay parity with equivalent professional groups or satisfactory working environments. While some nurses have effectively engaged in politics in different domains, stereotypical views of nursing (discussed in Chapter 1), along with the issues around the gendered nature of nursing (discussed in Chapter 3), have limited the full realisation of the potential of nurses and of nursing for political action, influence and advocacy. Nurses have been historically disadvantaged by professional role divisions positioning the practice of nursing as subservient to the practice of medicine (Carryer 2019). This positioning can inhibit nurses' sense of power and the capacity for productive action that their professionalisation confers. Carryer and Yarwood (2015) argue that societies' faith in biomedicine and nursing's acceptance of that has resulted in significant barriers to real transformation of health systems. While there is still a deeply held belief that healthcare provision must be led by the medical profession, obvious solutions to address health sector provision will not be realised.

Disparity between medical and nursing investment and development appears to be one of a number of political, practice power/gender and privilege issues. In terms of workforce development in Aotearoa/New Zealand, the investment in the medical profession is $6963 per person (increased by 5% in 2017). The nursing total equivalent is equated to $278 per person (0% increase in 2017) (New Zealand Nurses Association 2018). Willis and colleagues (2017) surveyed over 7000 nurses in Australia and New Zealand in the context of a global financial crisis whereby both countries have experienced increasingly significant budget cuts to health spending. The nurses identified that austerity measures had impacted on their workloads, which resulted in missed care, interventions that the nurses defined as necessary and unable to be provided due to unfair resource allocation. Consequences of health budget rationalisation have led to staffing levels based on patient/client numbers rather than acuity, the casualisation of the workforce and non-regulated role substitution of nurses (Willis et al 2017). Despite these challenges, nurses have considerable potential for action in this highly political arena.

The World Health Organization (2016) strategy recognises the key leadership roles that nurses have to play in achieving global health and social gains for people, which demonstrate the critical link between policy, politics, power and collectivism for the profession. These include:

- ensuring an educated, competent and motivated nursing workforce within effective and responsive health systems at all levels and in different settings

- optimising policy development, effective leadership, management and governance

- working together to maximise the capacities and potentials of nurses through intra- and interprofessional collaborative partnerships, education and continuing professional development

- mobilising political will to invest in building an effective evidence-based nursing workforce.

Taylor (2016) argues that nurses have a key role in active political advocacy to influence issues of social injustice, equity, access to healthcare resources and healthy working environments. Clarke and others (2017) propose that nurses must develop political agency as 'citizen nurses' who question the impact of complex political and power systems and collaborate with communities to bring about change, social justice and equitable health outcomes. Nurses have a vital political role to play in creating systems locally and globally that support humane and just healthcare provision by challenging the current dominant forces in healthcare systems. The integration of healthcare services, whereby hospital systems are not in competition with community systems, is crucial to future service delivery. Moreover, nurse-led models of care, connected community collaborations, advanced nursing roles and scopes provide evidence of what is possible when nurses assume professional structural and system influence (Rafferty 2017). Where nurses' political and professional power is limited, evidence suggests the impact to healthcare systems and patient/client outcomes are negatively affected (Rafferty 2017, Willis et al 2017).

Health is fundamental to life, and nurses are intimately involved in caring for the sick and supporting the healthy, either directly or indirectly, wherever they are working. Nurses are in a privileged position in that millions of people every day put their trust in nurses and assume that nurses will always work on the public's behalf. Nurses accept the obligations and expectations that go with being in a responsible and respected (particularly by the general public) role. With registration comes the commitment and accountability to work within a code of ethics, at the centre of which is the safety and wellbeing of those for whom nurses provide care. Key to the delivery of safe care is using the power that nurses have wisely, and being aware of the moral and ethical obligations because of this position of trust.

Every nurse has a degree of power. Even newly registered nurses immediately have power over patients/clients, who are nearly always in a less powerful position due to nurses' knowledge of both health and illness, and the healthcare system. Knowledge is linked to power, and just the ability to impart or withhold information puts nurses in a privileged position in relation to the people and/or communities with whom they work. When nurses are actively engaged and involved in institutional decision making, influence and governance, there are correlated positive benefits in terms of quality of care, efficiency, patient/client safety, retention, job satisfaction and financial performance (Brooks et al 2019, Kutney-Lee et al 2016). To be active in such a way, nurses require an understanding of power and its effects, and the way that they can use their power to enhance the health and wellbeing of people, along with their working conditions and professional status.

Power is often considered a negative and oppressive attribute. However, more recent definitions of the nature of power discussed in this chapter incorporate the notion of power as constructive and constitutive, as well as having the potential to be destructive and oppressive. These definitions also provide us with a way of considering power,

where nurses can be viewed as being powerless in certain situations but very powerful in other circumstances. This representation frees nurses from the idea of inherent powerlessness and/or being victims, simply through being nurses. Rethinking and reshaping of nurses' positioning in terms of agency is important in this era of intense governmental scrutiny and concerns about controlling health sector costs, which impact on the resourcing of nursing care and workforce planning, retention and education (Gilmour et al 2016).

Understanding power

Power is a complex and abstract concept that can be difficult to define or describe. It is, however, inherently a factor that exists in all systems and organisations. The need for nurses to understand the complexities of power dynamics and the impact power has on healthcare systems, the profession and the outcomes for people utilising health services is critical. Power can be considered a negative and oppressive attribute; however, used intentionally and effectively, power is necessary to influence, bring about change, social good and achieve desired outcomes for organisations or groups. Critical social researchers have informed an understanding of power in nursing by utilising the conceptual work of French philosopher Michel Foucault. According to Foucault (2003), where there is knowledge there is power, and power is at play when individuals exercise action upon themselves and others. We can consider that this relationship between professional knowledge and the ability to act affords nurses the capacity and the responsibility to assume legitimate power and act accordingly to wield influence within the healthcare domain. Vine (2004) describes power as necessary to getting things done and achieving the goals and outcomes of an organisation. This definition challenges other negative notions of the perhaps traditional understanding of wielding 'power over' other groups or individuals, which has been associated with controlling others with a goal of achieving obedience or conformity (Hokanson Hawks 1991). Katriina and colleagues (2013) propose that when power is considered as the ability to achieve goals, it becomes a significant and necessary resource for nurses to harness and utilise.

These definitions provide nurses with an alternate way of considering power and its use. It is necessary to recognise that power dynamics will be ever present but can be employed to act and pursue goals of improving people's health and wellbeing outcomes and influencing systems of care to be more socially just and effective. Cleary and others (2019) reminds us that the impact of 'power over' and 'power to' continue to have relevancy and implications for the nursing profession that require critical consideration. With its own professional research, knowledge and practice discipline, nursing has achieved a trusted social status that allows us the ability to act in a way that constitutes 'power to' influence, for individuals, communities and social systems. Nurses require power and agency to be effective in working within multidisciplinary teams and complex environments. Nurses who perceive themselves to be powerless are reported as being less efficacious and experience lower satisfaction with their work and, further, this can impact negatively upon patient/client outcomes (Cleary et al 2019). Perceived powerlessness and the concept of 'power over' in nursing continues to be a

limiting and problematic issue for the profession and the politics of practice.

REFLECTION

Can you influence your practice setting? If so, how do you exercise that influence? If not, what processes need to be in place to enable nurses the opportunity to voice concerns and ideas for change?

Politics and power

Politics permeate all aspects of life. Chaffee and colleagues (2012:5) define politics as 'the process of influencing the allocation of scarce resources'. Politics at state and national levels are often thought of as only involving government. Governments are critical bodies for regulating behaviour in that 'government lays down the "rules of the game" in conflict and competition between individuals, organisations, and institutions within society' (Harrison 2014:166). But politics, seen as the exercise of power in the form of influence, is also part of everyday life. Engaging in political action—learning to be more influential in relation to matters that count—is therefore both possible and necessary for all nurses. Sullivan (2013) suggests that influence exists through relationships and is more significant than authority. It is gained through position or respect for knowledge and skills. Influence is earned through effort and the skills to exercise this can be learnt, with the most crucial factor being the personal decision to become influential. Nurses tend to think that because they are good people doing a good job they should be valued and fairly rewarded and, if that does not happen, they blame themselves or the profession (Sullivan 2013). However, nurses may be unrewarded due to not effectively engaging in the underlying political game, which requires adherence to a particular set of rules that they may not know exists. Critically, nurses must recognise the existence and reality of politics, the legitimacy and necessity of being involved in politics and learn skills to gain greater influence if personal and professional goals are to be achieved.

Sullivan (2013) identifies some possible workplace strategies for developing influence, including:

- reciprocity with other workers (i.e. exchanging favours)
- having a good understanding of the informal information that circulates within the organisation
- employing non-confrontational approaches
- compromising when necessary to achieve a more important goal
- networking
- accepting responsibility for individual actions, both positive and negative,

and

- finding mentors, supervisors and high-level supporters.

The idea of playing workplace politics may not initially resonate with the cherished nursing ideal of teamwork. However, being influential and developing assertive and satisfying interdisciplinary relationships are essential contributors to nurses' agency in ensuring the provision of high-quality nursing care.

Nurses' collective political power

All people have political power as individuals, but nurses also have great potential as a collective body to exercise their power. In addition to an individual nurse's power in the patient/client relationship, nurses as a collective also have considerable power. In many countries, nurses are the largest occupational group in the healthcare sector. In 2018 in New Zealand, there were 58,206 nurses (enrolled, registered and nurse practitioners) (Ministry of Health 2019) and 267,721 registered nurses and 52,944 enrolled nurses were registered and employed in Australia (Australian Government 2019). Many of the reforms and restructuring that have taken place in Western health systems in recent years are focused on controlling and managing this considerable workforce. This is partially due to the perceived cost of providing nurses' services in the health sector. However, these same numbers give nurses power that can be used to influence the health system and improve it for the public. McKenna (2010:397) argues: 'If nurses began to speak with one voice, the power emanating from such a unified workforce would move political mountains'. Australian and New Zealand nurses are well educated at graduate level and have an evidence-based body of knowledge to support nursing practice. Nurses also work in wide-ranging roles in healthcare, spanning clinical, management, research, teaching and health policy domains that provide multiple opportunities to exert influence.

A key element of realising collective power is having formal ways to organise groups of people with a common cause that is well articulated and appeals to broad segments of the population. In nursing, the protection, support and influence derived from the power of the collective is realised through professional organisations. This power is shown clearly in situations such as the *Safe Patient Care Act 2015* and 2019 amendment which is landmark patient/client safety legislation to ensure in law the minimum number of nurses to care for patients/clients. As a result, 600 additional nurses and midwives were employed (Victoria State Government 2019). This legislation has had a major impact on the working environment for nurses. Similar work has occurred in Aotearoa/New Zealand with the mandated safe staffing healthy workplace partnership between the nursing unions and the District Health Boards (New Zealand Nurses Association n.d.). The Care Capacity Demand Programme (CCDM) provides methods with which to match patient/client care requirements with the appropriate nursing resource and includes acuity measures in addition to ratios (New Zealand Nurses Association n.d.). The goal of the program is to match the capacity to care with demand,

improve the quality of care, the work environment and the best use of health resources. Another example of collective bargaining power is the Multi Employer Collective Agreements negotiated by the New Zealand Nurses Organisation. These agreements would be impossible to negotiate at an individual level.

One of the most important choices a registered nurse makes is the decision to join a professional body. There are many organisations that primarily serve to advance the interests of the nursing workforce and the profession. As nurses, there is the opportunity to be involved and shape the political activity of these organisations through contribution as a member or at governance level. While nurses are often considered a homogeneous group, it is important to accept that nurses are enormously diverse. As a result, while the overall goal of nursing may be shared by everyone in the profession, individual nurses will not always share worldviews at either the macro or micro level. Therefore, using the power nurses have means being highly skilled at working not only with diverse population groups, but also with diverse nurses and nursing groups. Nurses have widely differing philosophical and political positions, and one strategy for managing this diversity is through the focus that professional organisations can bring. This means that individual difference can be accepted, but organisational power can focus on collective professional issues.

An example of nurses successfully using their collective political power to advance practice through the legislative process is the gaining of prescribing authority. Australian and New Zealand nurses and their regulatory bodies advocated for changes in legislation and governmental processes to enable nurses (usually advanced practitioners) to prescribe in their scope of practice. In New Zealand, extending prescribing rights to nurse practitioners was contentious, with some members of the medical profession, such as general practitioners, concerned about potential competition for funding or professional status and dominance (Carryer & Yarwood 2015). After a drawn-out and contested political process, the Medicines (Designated Prescribers: Nurse Practitioners) Regulations 2005 provided a framework for nurse practitioner prescribing. This initial legislative platform was a starting point in expanding the prescribing role of registered nurses in order to more effectively meet the treatment needs of specific population groups. Developments since include the Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011 and the Medicines (Designated Prescriber—Registered Nurses) Regulations 2016, which enable suitably qualified registered nurses to act as designated prescribers of a specified range of medicines in primary health and specialty teams (Nursing Council of New Zealand 2016).

Table 10.1 lists some ways of developing influence through knowledge, communication skills and action.

TABLE 10.1

Developing influence through knowledge, communication skills and action

KNOWLEDGE	COMMUNICATION SKILLS	ACTION
Nursing knowledge base		
Evidence-based clinical practice knowledge Patient/client and family knowledge/agendas/issues Policy/legislation knowledge at government, discipline and organisational levels	Articulate, respectful and assertive verbal communication Clear and appropriate written communication meeting academic/media/political/popular conventions, depending on context	Respond in a timely and coherent manner Document using appropriate channels Take opportunities to be involved in shaping policy through submissions and committee work Use information technology competently for communication and information retrieval
Understanding power		
Relationship of knowledge with power Power as a circulating force The capacity for resistance Differentiation of power relations and force relations	Professional introductions Title parity Adhere to professional code of dress Prepare accounts demonstrating importance of nursing work	Take leadership opportunities—formal and informal Accept responsibility Use knowledge to inform patients/clients and families Act as an advocate
Understanding the rules of the game		
Nursing Healthcare teams Organisations Communities	Network within and outside the profession Develop and use relationships with media and politicians	Develop respectful and communicative relationships within and outside nursing Be tenacious Enlist support from broader communities of interest in issues of concern to nursing

REFLECTION

Can you provide any other examples where the collective power of the nursing profession influenced healthcare system changes?

Power in practice

Knowledge carries with it power and authority, but not all forms of knowledge are created equal. In the preceding section on nurses' political power there was a discussion on the power that nurses have as a collective. However, there is ample evidence to suggest that nurses have been conspicuously silent, or have been silenced, at times when it has been vital that patients/clients have had vocal, assertive and knowledgeable advocates.

There has been a long history of documented instances where the devaluation of nurses' knowledge and authority by the medical profession has resulted in lethal consequences for patients/clients. One example is where 12 children died during or shortly after undergoing cardiac surgery in a Canadian hospital in 1994. Medical peers of the surgeon dismissed the validity of claims by several nurses that there were competency issues on the grounds that nurses did not have medical expertise (Ceci 2004). In another example where nurses were concerned about surgical competency, the repeated complaints of Queensland nurses about the actions of a surgeon, who was eventually implicated in at least eight patient deaths, were not acted upon by the hospital authorities (Johnstone 2019).

When nurses themselves feel powerless, however, they may choose not to act, and

this can also have dire consequences. One example of this was revealed during New Zealand's Cartwright Inquiry into cervical cancer, which investigated unethical medical research practices and the lack of informed consent about treatment options. Nurses throughout this period working at this particular hospital did not openly voice their concerns or ensure the women had been provided with the information necessary to make an informed choice about participation. Judge Silvia Cartwright stated that:

> *… nurses who most appropriately should be advocates for the patient, feel sufficiently intimidated by the medical staff (who do not hire or fire them) that even today they fail or refuse to confront openly the issues arising from the 1966 trial.*
>
> *(COMMITTEE OF INQUIRY INTO ALLEGATIONS CONCERNING THE TREATMENT OF CERVICAL CANCER AT NATIONAL WOMEN'S HOSPITAL AND INTO OTHER RELATED MATTERS 1988:172)*

Although by speaking out, the nurses at that time may not have been able to stop particular medical practices, their complicity through silence is something that nurses in New Zealand have had to acknowledge. Enduring perceptions of powerlessness surfaced again decades later in an English inquiry into standards of care and patient neglect in a National Health Service Trust where a nurse witness talked about nurses being afraid to report 'the poor standard of care the patients were receiving in case they incurred the wrath of the sisters' (Francis 2013:108). A construction of nurses as powerless and lacking in agency can lead to nurses behaving unethically and neglecting to put patients' best interests at the centre of professional obligations.

Buresh and Gordon have offered a powerful critique of nurses' lack of visibility and voice in the public arena, and suggest many strategies for 'moving to a voice of agency' (Buresh & Gordon 2013:75). Expressing agency is built upon the realisation of the importance of nurses' work and the confidence of nurses themselves. To make this agency explicit requires change at the fundamental level of day-to-day practice. Every encounter with patients/clients, families and other staff members is an opportunity to communicate, verbally and non-verbally, messages about the competency and the knowledge base underpinning nurses' decisions and practices. Expressing agency begins right at the first introduction to patients/clients and colleagues. For example, status can be reinforced through the use of both first and last names rather than just first name, along with title and role, a professional standard of dress and non-deferential body language. Buresh and Gordon (2013) have written extensively on the necessity for nurses to take every opportunity to educate people they meet about what they do and why they do it:

> *The appropriate use of voice is not a threat to either nurses or nursing. Silence is the threat to nursing. Nursing recognition that leads to respect, reward and resources hinges on individual nurses employing a voice of agency that accurately represents the experience of illness as well as the experience of those who care for the sick and vulnerable.*

(BURESH & GORDON 2013:75)

Nurses are highly educated practitioners with both formal education in, and considerable informal knowledge of, the culture and processes of the health system within which clients and patients find themselves. This has important implications for power relationships between nurses and the people for whom nurses care. An example of the everyday exercise of power is the categorisation of people through the practice of assessment and the ensuing allocation of resources to them. Assessment requires recording a range of information and judging whether a person meets certain predetermined criteria for normality and/or abnormality. The distribution of a wide range of resources, including the time and expertise of nurses and other health professionals, medical equipment, pharmaceuticals and access to the care setting, can be determined by nursing assessment. From a critical social justice approach, the assessment process therefore needs to incorporate opportunities for patient/clients and their families to exercise some control. This can be achieved by providing information about the purpose, scope and implications of the assessment in clear language, obtaining informed consent and validating the documented information with the person concerned. Similarly, nurses in inpatient/client hospital settings wield considerable power over family and friends' access to patients/clients.

Practising from a person-family/whānau-centred approach aims to enable people with patient/client control, and choice is a productive and necessary exercise of power. Power can also be used by nurses to improve practice and the experiences of the people and groups with whom we are working. Two particular situations or practices where power can be used by the individual nurse are highlighted. The first of these deals with seeking social justice and equity for people in terms of their health outcomes through advocacy. Secondly is the need to speak up for safe practice.

REFLECTION

How can power imbalances between you and your patients/clients be minimised in everyday practice?

ADVOCATING FOR PARTNERSHIP AND SOCIAL JUSTICE

Advocacy consists of taking action on behalf of a person, or supporting an individual or group to gain what they need from the system. This role is now considered a fundamental element of practice at all levels (Priest 2016). The *Code of Ethics for Nurses in Australia* states from the outset that nurses must take action when the standard of care is considered unacceptable: 'this includes a responsibility to question and report what they consider, on reasonable grounds, to be unethical behaviour and treatment' (Nursing and Midwifery Board of Australia 2018a). The increasingly overstretched and changing world of service delivery means that, more than ever before, nurses need to understand and enact this advocacy role at the micro and macro level.

Nurses may work on behalf of a person or group to advocate for resources or appropriate treatment and care. However, this approach could be seen as limiting the empowerment of individuals or groups; in many instances it may be more appropriate

to support a person or community to advocate for themselves (MacDonald 2006). It is important to recognise that acting as an advocate does not involve taking over the situation. This can result in a nurse acting out what he or she feels is best for the person, rather than acting to ensure that the person achieves what they want. According to the Nursing Council of New Zealand (2012a) *Code of Conduct,* partnership occurs when health consumers are given sufficient information, in a manner they can understand, in order to make an informed choice about their care and treatment, and are fully involved in their care and treatment. Their independence, views and preferences are valued. Nurses must be aware of the inherent power imbalance between themselves and health consumers, especially when the health consumer has limited knowledge, may be vulnerable or is part of a marginalised group. Supporting individuals or groups to take action still involves the nurse in an act of advocacy, but one that reflects a social justice approach to power, in which everyone *has* power but may need support and information to *enact* that power. If a nurse is not able to speak up for equity and social justice, then the appropriate action is to ensure that the person or group has access to another source of advocacy.

To be able to act effectively, speak up for equity and advocate for socially just outcomes for people using healthcare services, nurses need the following:

- understanding of the politics, culture and systems of health sector institutions and health service delivery
- understanding of the nature of power
- respect for the client or community and their rights
- understanding of relevant clinical issues
- understanding of ethical issues
- commitment to the client and/or group, and a professional obligation to act to ensure safe clinical care and health equity for people, and
- understanding of the need for evidence and the way it can be used to support decisions.

Advocating for equity and social justice can be used at all levels in the health system. It can be part of day-to-day practice in relationships with patients and clients, or it can involve influencing service delivery to enhance services for a client group or community as a whole. Advocacy at service delivery level aims to address health outcome disparities between different groups of the population. Nurses are well placed to detect access and treatment issues and advocate for services that provide equitable healthcare.

Many nurses are also key players in special interest groups working with people with

particular health issues. Patient/client and family representative groups are effective lobbyists often accorded a voice in health policy development. Joint initiatives with these groups offer productive alliances to further nurses', and health consumers', agendas focused on improving healthcare services. In New Zealand, recently the power of community voice led to a national inquiry into the state of mental health services (Health and Disability Commission 2018). As a result, a significant new direction of where, who and how services will be delivered is taking shape. The Australian National Disability Advocacy Program is focused on the rights of people with a disability to full community participation, and the promotion of choice and control in attaining personal goals and the use of support services. The program notes the range of disability advocacy models that can be employed, including systemic advocacy focused on long-term change addressing discriminatory policies and practices, and citizenship advocacy where people with a disability are matched with trained volunteer advocates (Department of Social Services 2018). It is important that nurses understand that there are limits to their advocacy skills, and that in some areas people may prefer external or non-health professional advocates. External advocates can be provided by special interest sector groups, or be paid independent advocates. Part of nurses' advocacy role is to be aware of the form of advocacy that is preferred by the clients or patients concerned, and to be able to discuss this in an informed manner.

Speaking up for safe practice is essential to achieving safe, effective, quality care (Morrow et al 2016). Nurses have a professional duty to put first the interests of the people they care for and act to protect them if they are at risk (Nursing and Midwifery Council 2019), although organisational elements such as trust, hierarchies, whether or not concerns will be believed and nursing confidence impact on whether nurses raise their concerns (Morrow et al 2016). Following the Francis (2013) report in the UK, the Nursing and Midwifery Council (NMC) (2019) has developed guidance on nurses raising concerns. Speaking up for safe practice calls nurses to act without delay, escalating concerns to the appropriate authority. There are stages of escalation that are recommended. Starting with the direct line manager, escalating to a higher authority if concerns are not reduced and then utilising regulatory bodies if the concern continues and is sufficient to warrant continued concern for patients/clients or public safety (NMC 2019). In Australia and Aotearoa/New Zealand, there are programs that support speaking up for safety through the development of organisational cultures, systems and processes to support communication that effectively raises concerns. At the high end of speaking up is whistleblowing, which is described as employee information disclosure about misconduct, illegal, unethical or illegitimate practices that are within the control of their employers, to a person or an organisation that has the authority or power to take action (Johnstone 2019). Further, there may be public disclosure to authorities external to the organisational reporting processes. A key reason for whistleblowing is that there is something significantly wrong that has or will cause serious harm that is not being paid attention to by the organisation, having raised it in appropriate channels (Johnstone 2019).

The reported concerns in the whistleblowing context about retribution (Francis 2013, Moore & McAuliffe 2012) are not surprising given the substantial published nursing

discussion and research focused on the concept of horizontal or lateral violence (discussed in Chapter 1), also labelled as bullying, incivility, disruptive behaviour and hostile clinician behaviours (Hutchinson & Jackson 2013, Roberts 2015, Thomas 2012). If nurses perceive a lack of support, in environments where communication is ineffective or where hierarchies and power dynamics negatively affect them, they are less likely to speak up for safety (Morrow et al 2016). Nurses who do use safety voices to raise evidence-based concerns are courageous and need the support of nurse leaders, colleagues, friends and family. Too often, those who choose to take a stand can feel isolated and are at risk of reprisal, such as harassment and loss of employment (Jackson et al 2010, Johnstone 2019). A study, contrasting the responses of nurses who reported a care issue with those who did not, found both groups had concerns about retribution, and that non-reporters were more likely to cite reasons for inaction as being uncertain about being correct and not wishing to create trouble (Moore & McAuliffe 2012). Healthcare workplaces are spaces where disrespectful and hostile staff behaviours, such as harsh criticism, belittling comments and not helping others, affect many nurses (Dumont et al 2012).

When practising in complex and challenging work environments, nurses need to be resilient. The concept of 'personal resilience' is considered important in terms of being able to positively cope with adverse situations and practise in difficult workplaces. Resilience involves developing strategies such as productive professional networks and focusing on personal development in areas such as the maintenance of a positive attitude, work–life balance and emotional insight (Hart et al 2014, Tiziana et al 2019). However, the moral obligation to act in instances of poor-quality care is not solely an individual nurse's concern—health professionals and other staff have a collective responsibility to create conducive environments for quality patient/client outcomes. The Nursing Council of New Zealand (2012a:28) articulates in the *Code of Conduct for Nurses* the expectations for professional behaviour, including working respectfully with colleagues 'in a professional, collaborative and co-operative manner'. This code, like many others internationally, recognises that others have a right to hold different opinions. The public media has been used by some whistleblowers to draw attention to health issues. The media can serve a useful purpose in promoting accountability but it also creates intense public scrutiny and critique, confidentiality concerns and may present an unbalanced picture. There are similar concerns about the role of social media as an instant but unmoderated communicative avenue. Major breaches of patient/client confidentiality have led to the development of social media guidelines for nurses and other health practitioners (Australian Health Practitioner Regulation Agency 2014, Nursing Council of New Zealand 2012b).

Not all nurses who have spoken up for unsafe practice have personally experienced workplace retaliation when reporting unsafe patient/client care, but it does exist. The nursing profession, in particular nursing leadership, holds a powerful influence to facilitate a culture of safety. This includes proactively addressing unsafe practices, fostering advocacy and standing with nurses who speak up (Cole et al 2019). The need to legally protect people in whistleblowing situations is recognised with specific legislation aiming to ensure disclosures are investigated and to protect whistleblowers

from retaliation. In New Zealand, there exists the *Protected Disclosures Act 2000*, while in Australia the legislation is variable across jurisdictions about who is eligible for protection and the type of public sector wrongdoing covered (Brown 2006) and so it is essential to investigate what the applicable legislation provides in terms of protection (as noted in Chapter 9).

The serious lapses in safe and humane healthcare noted in this chapter are rooted in systemic organisational inadequacies; as individuals, nurses have been driven to bravely act against prevailing practices or, alternatively, have been part of the invisible forces enabling injustices to be perpetuated. Recent professional responses have been to clearly articulate to health services the criteria to be used as a basis in monitoring and improving the quality and safety of healthcare, along with health professional accountability, to act effectively when patient/client safety is at jeopardy (Nursing and Midwifery Board of Australia 2018b, Nursing and Midwifery Council 2019, Nursing Council of New Zealand 2012a).

CONCLUSION

Nursing services are pivotal in the provision of healthcare. Nurses are mediators between healthcare institutions, with their associated mysterious practices, language and technologies, and people and their families/whānau—translating and making the health system understandable for the individual or community. Nurses are a powerful group, expert in terms of their knowledge base, their practice and their understanding of the impact of health on people and communities. This knowledge and experience places the nurse in a very powerful position in terms of being able to influence people they are working with and speak up for an equitable and socially just healthcare system. Understanding and being consciously political at both the collective and the individual levels is central to working with patients and clients to improve their experience of healthcare and their health outcomes.

REFLECTIVE QUESTIONS

1. Do you think you are influential as a nurse? If so, how have you become influential? If not, how could you be more influential?
2. What do you think patient/clients and families need to know to be effective advocates for themselves and others?
3. What do you think are the most important steps to take when raising concerns about healthcare issues?

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CHAPTER 11: BECOMING A NURSE LEADER

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KEY WORDS

clinical; leadership; management; evidence-based; practice; nurse; practitioner; transformational

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- describe the social, economic and political trends influencing nursing practice globally;
- identify the differences between the terms ‘leadership’ and ‘management’;
- recognise strategies for undergraduate nurses to develop to become nurse leaders;
- appreciate the importance of evidence-based practice in facilitating optimal patient outcomes;
- identify professional and organisational factors that facilitate effective leadership and strategic management.

INTRODUCTION

Leadership is an attribute of an individual who inspires and motivates others to work towards a defined goal or mission (Daly et al 2015). Contemporary health systems are dynamic and exist in complex social, political and economic ecosystems. Unless nurses choose to be swept along by change, they need to actively engage the process on both a personal and a professional level. We live in a global environment and this has implications not just for health but also for professional practice. Recent epidemics such as Ebola and novel coronavirus (COVID-19) emphasise that we are highly interconnected across the planet and need to consider health in a global context (Zhu et al 2020).

Expert nursing practice extends beyond knowledge, skills and competencies to translation and implementation. This requires harnessing resources, energy and enthusiasm in enacting the philosophy and vision of nursing. Nursing leadership is critical for implementing evidence-based practice, promoting optimal patient outcomes and optimising the value of healthcare within ethical frameworks (Davidson et al 2018). Although individual countries have discrete issues, across the globe healthcare systems and nurses are facing similar challenges in delivering quality, high-value and accessible healthcare. Increasing geopolitical instability across the world underscores the importance of considering healthcare within a social, political and economic context. The growing burden of chronic illness and ageing of the population increases the importance of coordinated care led by competent, credentialled and capable nurses practising to the full extent of their education and training (Davidson et al 2013). Promoting quality and excellence in nursing care and ensuring safe and effective work environments is important in providing high-quality patient care.

Emerging from the increased pressures of demand for clinical care, an emphasis on access and fiscal constraints has given rise to the Triple Aim, dictating a course for enhancing patient experience, improving population health and reducing costs and underscoring the importance of leadership. Stressors in the healthcare system have led advocacy for the Triple Aim to be expanded to include a fourth element, a Quadruple Aim, adding the goal of improving the work life of healthcare providers, including clinicians and staff (Fitzpatrick et al 2019). Although emerging from the United States (US), this approach is rapidly gaining global currency as the influence of the welfare of healthcare professionals becomes more apparent (Osborne et al 2019). This philosophical perspective is an important strategy for creating positive and enabling environments to promote optimal health outcomes and includes consideration of patient, provider and systems issues. There is an increasing concern regarding the impact of burnout and moral distress experienced by nurses and the need to consider work environments that promote wellbeing (Rushton 2016). We also need to increase diversity in our workforce and ensure that our profession reflects the cultural diversity and pluralism of contemporary society (Mackean et al 2019). This chapter will discuss the desirable attributes of leaders in the clinical workplace and the role of expert clinical practice in forging a professional identity for nursing. The chapter will also provide

insights into the way expert practitioners, functioning as leaders in the clinical setting, can face challenges and successfully implement strategies to improve patient care and advance nursing practice. The first section of the chapter sets the scene in describing contemporary trends influencing clinical practice, models of nursing care delivery and aspects of leadership in the clinical setting and the later part focuses more specifically on becoming a nurse leader.

As you read through this chapter, it is important as a beginning nurse to consider the attributes that you need to develop to become a nurse leader and how these manifest in modern healthcare environments. It is never too early to focus on developing your leadership style, beginning to critique others' leadership styles and preparing to transition from being a student to a registered nurse. You will soon learn that quickly after becoming a registered nurse you will be expected to manage care and provide leadership for critical patient care issues.

Effective leaders cultivate a self-reflective appraisal of their strengths and weaknesses as part of a lifelong learning process. Nurse leaders also engage in activities to develop competencies and skills in their personal and professional life. Leadership is crucial at all levels of nursing practice—from novice to expert. You will observe leadership styles that are positive and enabling as well as dominating and destructive. Unfortunately, you will probably experience each of these leadership styles in your career. Learning to work with a range of leadership and managerial styles as well as clinical practice settings is an important part of your personal and professional development.

As you observe the behaviours of your peers, you can probably see the emergent characteristics of future nursing leaders; for example, how your colleagues deal with challenges in both the classroom and the clinical setting. Increasingly, we are aware that the level of nursing competence, staffing and communication as well as the quality of working environments influence patient outcomes (Halm 2019). Even in your early days of practice, you can shape the future of patient care and the nursing profession through engaging in critical discussion, student leadership, reflective practice and providing a voice for patients and their families. This will require focusing on both your personal and professional development as well as forging your nurse identity.

REFLECTION

What do you consider to be the attributes of an effective leader?

How do different leadership styles contribute to clinical effectiveness and improving patient outcomes?

Internationally, clinical, administrative and policy environments in healthcare generate challenges to both professionals and consumers. Increased demands for clinical services, rising healthcare costs, and health workforce shortages are just some of the issues you will face as you begin your nursing career. In spite of these challenges, the healthcare setting has never been so welcoming for dynamic nurse leaders and managers. Contemporary healthcare systems are no longer based upon hierarchical medical leadership but are more inclusive and interdisciplinary (Stone et al 2019). Moreover, never before have nurses been so well educated and prepared to lead clinical

practice.

An increasing body of evidence demonstrates the unique contribution nurses make to patient care. Nurses need to be empowered to provide leadership and direction for models of care development and delivery in policy, practice and research. At many levels you will see nurse leaders functioning in organisational, policy and nursing-specific leadership (Fischer & Nichols 2019). The growth of nursing research and scholarship has demonstrated the unique and valuable contributions of nurses to health-related outcomes, particularly related to promoting continuity and coordination of care. Nurses are not only in leadership positions but also demonstrating the contribution of nursing care to patient outcomes (Griffiths et al 2019).

Given the importance of skilled nurses in achieving optimal patient outcomes and overcoming global nursing workforce shortages, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) in the US launched a two-year initiative in response to managing the challenges of contemporary healthcare systems. Four key messages were identified as part of this process:

1. Nurses should practise to the full extent of their education and training.

2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

3. Nurses should be full partners, with physicians and other healthcare professionals, in redesigning healthcare.

4. Effective workforce planning and policy making require better data collection and information infrastructure.

This visionary and strategic report underscores the importance of independent nursing practice and the relationship to patient outcomes. This vision labels a clear path to the importance of interprofessional practice. Although this report focuses on the US it has resonance internationally for nursing development. A review of progress against these goals in 2015 has found significant improvement but reaffirmed the emphasis on increasing the educational level of nursing, growing the number of doctorally prepared nurses, promoting diversity, interprofessional practice and nurse residency programs as well as ensuring more accurate methods of data collection and monitoring of workforce data.

The mandate for advanced practice creates an exciting milieu for nurses to work in an interdisciplinary context. These new opportunities create increased responsibility to work with an evidence-based, ethical and collegial framework. Accountability, integrity, ethical and expert practice are core values of all professions. For nursing, this should be the essence of our work and manifest in our practice and interactions. For nurses to function effectively in dynamic clinical environments and exert their influence to optimise patient care, they need to appreciate the multiple factors that impact nursing practice and healthcare delivery. These factors are as diverse as the nature of

nursing practice. It is also important to consider that, regardless of the healthcare system in which you will work, healthcare delivery is provided in a political context that is strongly influenced by economic factors and prevailing cultural and social values. The crucial role of leadership has been recognised in many aspects of nursing practice and professional interactions. In this chapter, we explore clinical leadership within a global context and discuss the implications for developing enabling knowledge, skills and attitudes to perform professionally and with credibility in policy, education, practice and research.

Healthcare in context

Contemporary healthcare settings are often portrayed as systems in crisis as they battle increasing demands and diminishing resources. These issues are common in both high- as well as lower- and middle-income countries. Across the globe, an ageing population and the increasing burden of chronic conditions challenges healthcare delivery and professional practice. Currently, many healthcare systems are designed for acute procedural care where current epidemiological trends emphasise the importance of population and community-based care. Evolving, emerging economies, such as China and Thailand, face unique challenges relating to the changing status of nursing and rapid epidemiological transition. Nurse leaders in these countries are leading systemic change in healthcare systems and advancing nursing practice. Globally, nurses are recognised as a critical ingredient to improving healthcare delivery (Iro et al 2019).

The worldwide nurse staffing shortage continues to attract government and public comment. Nurses, along with many other professional groups, are experiencing workforce shortages exacerbated by increasing demand and an ageing workforce. This emphasises the importance of considering nursing workforce issues within the context of global economies and 'human resources for health' strategy (WHO 2016).

Pointing the finger at nurses and nursing models of education creates an all-too-easy scapegoat for the deficits in the health system and the perception of decreased influence of clinical training in universities. Paradoxically, there is increasing evidence of the impact of improved clinical outcomes based on the level of the educational preparation of nurses. Increasing challenges facing healthcare are global and strongly mediated by factors such as epidemiological transitions, increased migration and geopolitical instability. Taking the time to consider these forces is critical in assessing current clinical situations and planning for your future and the nursing profession's future. Given the increasing globalisation of health and emphasis on internationalisation, there is an emphasis on global competencies for health professionals. Across the world, there is an increasing number of refugees, many of whom are forcibly displaced. The World Bank predicts that nearly half of the world's poor will live in fragile and conflict-affected states by 2030 (Orcutt et al 2020). Commonly, nurses and other health professionals are powerful advocates for health and human rights.

REFLECTION

What is the role of nursing leadership in upholding human rights such as the care of refugees and the care of children in detention camps?

As you begin your nursing journey and struggle with acquiring skills and terminology, terms such as 'leadership' and 'mentorship' can appear distant, remote and have limited relevance. However, it is important to consider that you and your colleagues are the nurse leaders of the future and have a personal and professional responsibility to develop the necessary skills and competencies. Leadership is rarely a historical accident; rather, it is a set of knowledge, skills and attributes that are

developed over time and enacted in particular situations (Cummings et al 2010). As you read this chapter and reflect on the exercises, consider the knowledge and skills that you will need to develop to prepare yourself for a leadership role.

The skill mix of nursing in the clinical setting is increasingly diversifying, particularly with growing numbers of enrolled nurses, technical and assistant roles (Jacob et al 2015). The registered nurse will increasingly take on a role of leadership and coordination. No matter how small or large your clinical team is, you will need to inspire, motivate and lead your team to achieve negotiated goals and deliver effective clinical care. Skills such as effective communication, reflection, listening and critical thinking are crucial in developing these roles. Take the time to develop these skills and to seek feedback from your peers.

Opportunities for clinical nursing leaders

A commitment to equity and access is driving healthcare reforms in many countries, such as Australia, New Zealand, the United States, the United Kingdom, Thailand and Malaysia. Nurses undertake a crucial role in these reforms, from the primary to tertiary care sectors. Technological innovation has improved clinical outcomes for many non-communicable diseases (NCDs). These NCDs (heart disease, stroke, cancer, diabetes and chronic respiratory diseases) will be a high burden on societies globally and, importantly, will place significant pressures on the healthcare system (Peters et al 2019).

Healthcare professionals are increasingly challenged to deliver healthcare in an equitable and accessible manner while dealing with issues of quality, safety and fiscal responsibility. Globalisation refers to the increasing patterns of interdependency throughout the world attributable to migration, knowledge exchange, communication and trade patterns. Globalisation and health are inextricably linked and increasingly we need to consider issues beyond our local environment in healthcare policy and delivery (Davidson et al 2003).

STORY

Jackie's first clinical appointment was in the cardiothoracic intensive care surgical unit following a 12-month new graduate placement program. Following this program, Jackie was starting to feel confident in clinical skills and mastering time management. Starting in the intensive care unit propelled her back to the feelings of inadequacy and anxiety of her first few weeks of practice. These emotions were exacerbated by a particularly busy day in the unit and the patient she was assigned having a postoperative bleed following cardiac bypass surgery, requiring a return to the operating room. Unfortunately, this patient died on the operating table and Jackie had to deal with distraught family members and the devastation of the clinical team.

Going home after that shift Jackie felt awful, racking her brain trying to consider if she should have identified any clinical signs earlier, or if she could have done any more or anything better. She had a sleepless night and returned to work the next day with fear and trepidation. The second day was much less eventful, but she still felt scared. The pace and intensity of the work were daunting and getting used to the new

equipment and staff was challenging.

On her shifts she avoided taking breaks, taking extra time to catch up on her work. At night she was not sleeping well. On day 5 of the week, when the supervisor asked her when she expected to discharge a patient from the ICU, she burst into tears.

Reflective Questions

Please consider both Jackie's situation and that of the intensive care unit and nursing leadership.

1. How could Jackie have coped better with her first week?

2. What strategies could the unit have implemented to ensure a less stressful transition?

3. What is the role of the nurse leader in this setting?

REFLECTION

The story above is a complex scenario reflecting the reality of the clinical setting with many important messages, but four key points to make are:

1. All clinical units should have orientations and it is the role of clinical leaders to ensure their colleagues are supported.

2. Debriefing after critical incidents is important for both continuous quality improvement as well as team cohesion.

3. Clinical leaders (e.g. shift supervisors and nursing unit managers) should monitor new employees for their coping and adjustment.

4. As a new staff member, Jackie should have spoken out earlier about her fears and anxieties. Seek mentors and role models early and be comfortable asking for help.

The burden of tuberculosis (TB) and HIV AIDS are just some recent examples of clinical conditions that have resulted as a consequence of living in a globalised world. For example, TB, once considered contained, is spreading across the globe fuelled by factors such as migration and also antimicrobial resistance (Reid et al 2019).

Frequent travel, migration, geopolitical instability and other social and political factors can impact the health and wellbeing of individuals and communities through the spread of disease and political and social unrest. In many countries throughout the world, issues such as refugee health and migration challenge the health and social care systems and also polarise community opinion. The emerging refugee crisis in Europe and other parts of the world is challenging healthcare systems (Takahashi et al 2019).

Within a climate of healthcare reform, nurses now also have increasing opportunities to influence healthcare policy and practice globally (Iro et al 2019). This new position of power is evidenced by nurses holding influential positions and driving practice changes following credible scientific research and advocacy. Nurses are also working in advanced practice roles such as nurse practitioners (NPs). NPs are trained to comprehensively assess the needs of patients, order and interpret diagnostic and laboratory tests, provide diagnoses as well as formulating and prescribing treatment plans. Significant barriers may exist in advancing nursing roles, such as opposition from powerful groups, including medical organisations (Casey et al 2019). However, these challenges are not insurmountable and stewardship by effective nurse leaders is necessary. Demonstrating outcomes that show the quality and safety of nursing and midwifery care is critical in gaining acceptance and endorsement.

There are examples across a range of nursing and midwifery practice where innovative models of care have improved patient outcomes by challenging traditional views and perspectives. Innovative models of midwifery care, such as early discharge care, have improved the experiences of mothers and their babies as well as achieving cost containment (Scarf et al 2016). Recognising that the greatest power base for nurses and midwives exists within the practice domain is important. The demonstration of clinical excellence and innovation is an important factor in overcoming scepticism surrounding an innovative practice. For example, nurses in the management of chronic heart failure have demonstrated their ability to influence patient outcomes and policies through nurse-coordinated programs and advanced practice nursing roles (Koirala et al 2018).

As a consequence, clinical leadership in the practice setting is an important tool and strategies to achieve this are discussed below. A clinical leader is a nurse who demonstrates the ability to influence and direct clinical practice. This clinical leader also has an ability to forecast the direction of practice and healthcare delivery as well as the knowledge, skills and competencies to develop a strategy and the ability to execute it. The vision of clinical leaders is informed by expert knowledge, evidence and an analysis of the social, political and economic trends influencing healthcare as well as ethical principles. Potential pandemics such as Ebola and COVID-19 are salient examples of the need not just for expert practice but also clinical leadership and ethical practice (Wang et al 2020). Contemporary nursing leaders need to be flexible and innovative in collaborative practice models. Pressures on the healthcare system—for example, financial pressures and increasing chronic disease burden—represent significant challenges for nurses. However, innovative models of care, increasing emphasis on independent nursing practice and institution of clinical governance structures will likely serve nurses in addressing these challenges.

REFLECTION

Consider the barriers and facilitators impacting on the implementation of the nurse practitioner role in your practice setting.

Policy frameworks for nursing practice

Directing change and asserting leadership in an organisational system requires an appreciation of barriers and facilitators to achieving desired outcomes. This observation is relevant at both a macro and a micro level of operation. Politics and organisational strategy can be just as intriguing and complex within a hospital ward or community health centre as at the bureaucratic or parliamentary levels. However, at all levels, it is important to be aware of social, political and economic factors that influence healthcare delivery. Politics in nursing is discussed in more detail in Chapter 10 of this text.

The working environment of nurses is influenced by the social, economic and political systems of the healthcare system. These factors influence practices and trends in healthcare delivery. In some instances, policy can be either a barrier to or a facilitator of clinical leadership. Although the NP role is well established in the US, barriers to practising to the full extent of their licence are still apparent. The emerging role of the NP in Australia, Thailand and New Zealand is an example where significant policy and legislative reform has created a context to promote advanced nursing practice in spite of opposition and scepticism from some medical professional groups (Scanlon et al 2016).

A shortage in numbers of medical practitioners has seen evolving roles in emerging economies such as Thailand, Nepal and Africa. Policy initiatives in the United Kingdom have seen the embedded nature of practice nurses working in general practice, whereas in Australia this is an emergent and evolving role (Halcomb & Ashley 2019). Internationally, healthcare professionals strive to ensure the delivery of safe and effective evidence-based care. Frameworks to monitor the quality and safety of healthcare are important in monitoring the efficacy and effectiveness of nurse-led models of care.

Strategies for promoting the quality and safety of patient care are mechanisms through which healthcare organisations are held accountable for adhering to evidence-based practice standards, continuously improving the quality of their services and ensuring high standards of care. As you engage in your clinical placements and nursing studies, consider the factors in which nursing care can shape the outcomes of patients. Fall prevention, mouth care and pressure care are examples of essential nursing care that influence patient outcomes. Increasingly, considering the complex factors within healthcare systems can also influence nursing practice and patient outcomes (van Kraaij et al 2020). Measuring nurse-sensitive patient outcome indicators, which are nursing activities that influence patient outcomes, is of increasing importance (Driscoll et al 2018).

Changing models of care delivery

A variety of care delivery models are used in healthcare—some relate to nursing only and are historic, while others are interdisciplinary and responsive to emerging practice trends. The changing healthcare environment—characterised by increasing short-stay surgery, decreasing lengths of stay and numbers of acute beds, combined with increasing patient acuity related to comorbidities—requires vastly different models of care delivery from even a decade ago. Novel models of care are commonly developed in response to actual or perceived deficits in existing care delivery.

REFLECTION

Identify a nurse-sensitive patient outcome indicator (e.g. falls prevalence) appropriate to monitor in your clinical setting.

A description of common nursing models is provided in Table 11.1. It is important to note that to date the majority of investigations of nursing care have been undertaken in the acute care setting. As healthcare shifts to the community, it is important to consider not just models of care but educational preparation (Murray-Parahi et al 2016). Ensuring a negotiated taxonomy and relevance to scope of practice in local contexts is likely to be of great importance for future models of nursing care. Patients are admitted to acute care hospitals primarily for collaborative or independent nursing care, as many medical diagnostic and therapeutic procedures can now be conducted in ambulatory care settings, except in critical or emergency circumstances. However, efficient and effective care also requires continuity of patient management beyond the traditional hospital admission period to encompass the entire episode of care, particularly for those with continuing chronic disease.

TABLE 11.1

Common care delivery models

CARE DELIVERY MODEL	CHARACTERISTICS
Functional nursing	Ward-based care with allocation of specific clinical tasks, such as medication administration, to nursing staff.
Team nursing	Ward-based care where a small team of nurses (perhaps with different educational preparation, skills and competencies) provides care to a designated number of patients.
Patient allocation/total patient care	Ward-based care provided by a registered nurse on a shift-by-shift basis to a defined number of patients.
Primary nursing	Ward-based care with a registered nurse assigned to patients for their entire admission period. Within this model a plan of care is developed, implemented and evaluated by the 'primary' nurse, with 'associate' nurses continuing the plan in the absence of the 'primary' nurse.
Care management/clinical pathways	Ward- or hospital-based multidisciplinary coordinated patient care for a specific case type (e.g. patients with total hip replacement). This model frequently incorporates a 'critical' or 'clinical path' tool to 'map' and document care, including the sequence and timing of interventions and variances from expected outcomes.
Case management	Hospital, outreach and/or community-based multidisciplinary care that provides continuity of care for a specific case-type of patients (e.g. patients with heart failure and chronic obstructive pulmonary disease) across the entire episode of care from hospital to community.
Interprofessional practice	Models of care where two or more professional groups work synergistically and collaboratively to achieve shared goals to improve patient care.

Telehealth	Telehealth is the application of digital information and communication technologies, such as computers and mobile devices, to provide healthcare.

Source: Adapted from Davidson P M, Hickman L 2012 Managing client care. In Crisp J, Taylor C (eds) Fundamentals of nursing, 4th edn. Elsevier, Sydney, p 129.

Programs that promote nurse coordination of care are emerging across many diagnostic conditions, including cancer, diabetes, heart disease, arthritis and chronic obstructive pulmonary disease. Similarly, there are programs in early childhood and midwifery care. As you consider your options for nursing in the future, it is important to remember that a large proportion of nursing care will be provided in the community and primary care settings. Many countries around the world are adopting primary healthcare approaches to decrease health disparities and the lack of dependence on the acute care setting (Mukherjee et al 2019). The World Health Organization (WHO) has designated 2020 as the Year of the Nurse and Midwife. Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO, has emphasised that nurses and midwives are crucial to achieving Universal Health Coverage and the 2030 Sustainable Development Goals.

Increasing adoption of technology will see nursing interventions delivered by telehealth and web-based media. This is likely to require the development of a suite of skills and resources to work in this setting effectively. Performing effective interventions over the phone or internet are likely to be of increased importance. This will also have implications for the regulation of professional practice and the monitoring of health outcomes (Cloyd & Thompson 2020).

Leadership in action

An important attribute of a leader is to formulate an action plan and support their team in achieving negotiated goals. There is an increasing discourse and discussion of leadership within the nursing profession. The concepts that make nursing leadership unique are the requisites for evidence-based healthcare: responsibility for the care and safety of patients and the need for evaluation of clinical practice. Leadership has long been an important part of the function of any organisational structure. Leadership styles vary along a continuum from authoritative to participatory, although common characteristics for leaders include being a visionary and having a plan to take individuals and services into the future. Leadership is influenced by the values of individuals and organisations, as well as society. Values are a set of beliefs and concepts derived from knowledge, experience and aspiration.

Values can be: *personal,* such as the importance placed on honesty and integrity; *professional,* such as the emphasis placed on reflective practice, accountability and continuing professional development; and *organisational,* such as the emphasis placed on patient outcomes and adherence to policy. In order to function effectively and avoid role conflict, there needs to be a congruency between the values and beliefs of the individual and the organisation in which they work. Where there is a mismatch is often a recipe for discord, conflict and low work satisfaction.

As you choose your work setting, it is important that you take the time to understand

the mission and values of the organisation and ensure that these are congruent with your own belief system. The confluence between personal, professional and organisational values and leadership styles can often determine not only successful leadership but also your 'fit' within an organisation. That is how committed you are personally to the direction of the organisation and how happy you are within the organisation. The power of nursing to drive social change cannot be underestimated. The social change model promotes equity, social justice, self-knowledge, service and collaboration in nursing students and is one model of increasing personal potential for leadership (Read et al 2016). From the origins of contemporary nursing in the work of Florence Nightingale, nurses have been advocates for improving access and quality of care. It is for this reason that nurses are consistently voted the most trusted professional group across the globe. In order to promote leadership, communication strategies are important. Emerging strategies, such as social media, increase the capacity of nurses to engage in advocacy and advancing patient care (Ferguson 2013).

Fig. 11.1 describes the desirable attributes of effective clinical leaders. This leadership is linked to the cultural values of the systems, resources and support available. A distinction of leadership characteristics is made between transactional, transformational, connective, renaissance and other leadership styles (Jackson & Hutchinson 2015). Transactional leadership focuses on transactions or exchanges between leaders and others, with self-interest the key motivator. In contrast, transformational leaders create a culture of leadership for all stakeholders, generating empowerment, open dialogue and inclusive decision making. An additional concept, 'breakthrough leadership', incorporates role modelling, clarification of own values and respect for others' views. Role modelling, mentoring and succession planning are vital aspects in preparing current and future nursing leaders.

FIGURE 11.1 Attributes of a clinical leader

Jackson describes servant leadership as an important and emerging trend where the servant-leader does not work in isolation, but rather actively searches for opportunities to build connections to promote creativity and enabling mutually beneficial relationships (Jackson 2008). Regardless of the leadership style, it needs to be a good fit with broader organisational contexts to promote quality and safety of patient care and the work satisfaction and retention of nurses in the workplace (Cummings et al 2010).

What makes a clinical leader?

In organisations such as hospitals and community health settings, there are different nursing leaders functioning at all levels. The individuals who readily come to mind are

often those who are very visible in organisations, such as directors of nursing. However, it is important to differentiate between management and leadership. Management refers to the planning and organisation of services. The term 'leadership' infers that an individual is visionary and pivotal in directing and shaping clinical practice. Implicit in functioning as a clinical leader is a significant mentoring role as shown in Fig. 11.2.

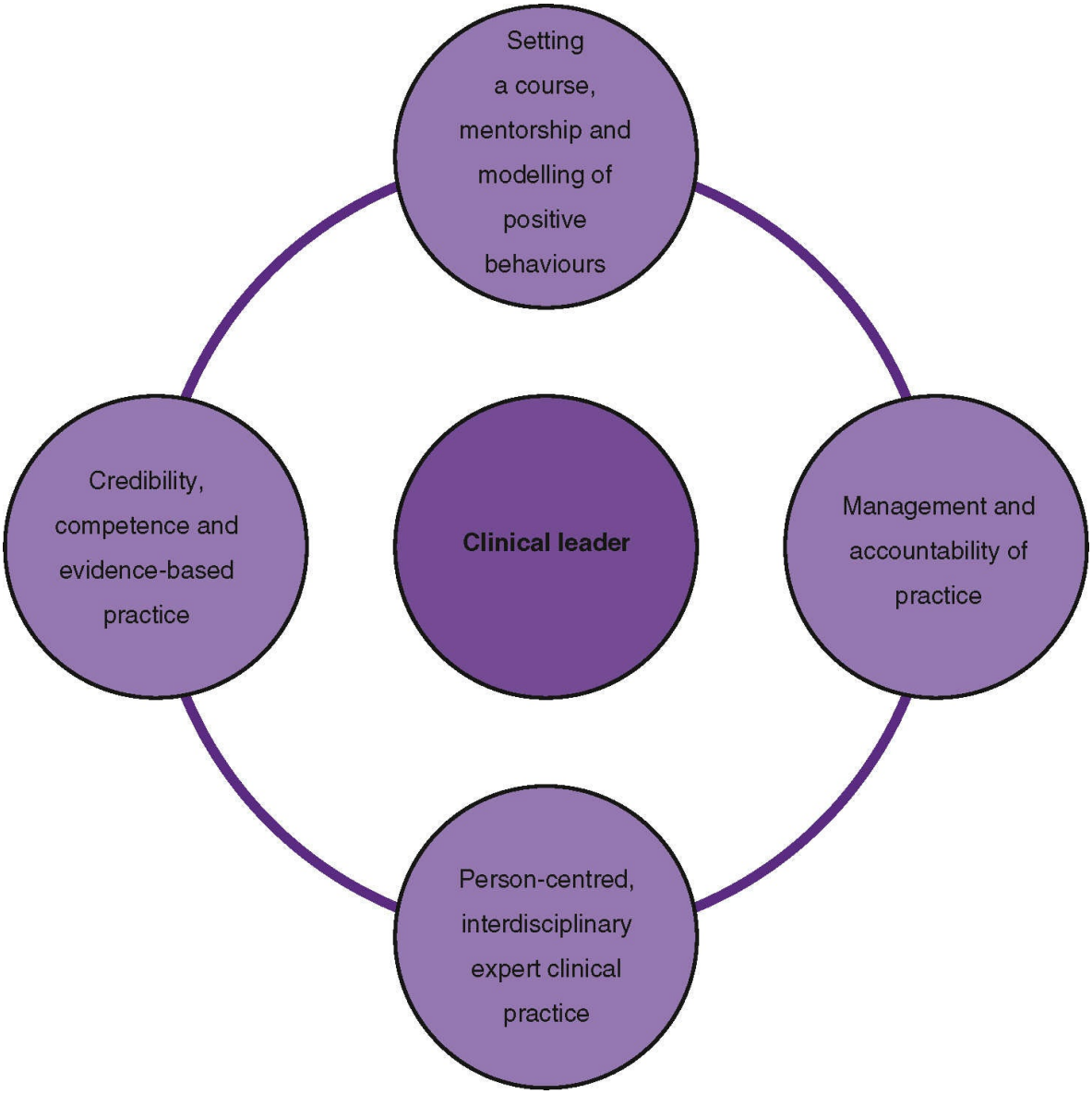


FIGURE 11.2 Framework for being a clinical leader

These attributes show that the clinical leader is not only an expert clinician but applies a range of skills to address the needs of patients and colleagues. In discussing clinical leadership, it is important to challenge the assumption that the leader making the difference to care is at the hierarchical apex of the organisation. Clinical leaders are involved in providing and directing patient care and are experts in their field. Often a differentiating focus between vibrant research-inspired, evidence-based practice cultures and those based upon historical and hierarchical practice is the nursing leader (Moore et al 2019). Organisations that foster nursing leadership by involving personnel in decision making and promoting nursing research and innovative practice frequently have better patient outcomes.

Increasing numbers of individuals are living with chronic and complex conditions

and require the professional services of different occupational groups. Nurses have demonstrated their ability to work as part of a team and be collaborative and participatory in their actions and decision making (for more on teamwork, see Chapter 12).

There are two critical factors in healthcare as clinicians face the complexities of current patient care: the need for clinical expertise and the need for these professionals to collaborate. Interdisciplinary healthcare teams with members from many disciplines increasingly work together to optimise patient care. Examples of these teams are found in trauma, neonatal retrieval, geriatric assessment and drug and alcohol areas of clinical practice. Increasingly, there is an emphasis on interprofessional learning to promote interprofessional practice. Promoting nursing students to understand their own professional identity while gaining an understanding of other professionals' roles on the healthcare team is an important strategy for preparing for professional practice.

Promoting leadership in the practice setting

Given the challenges facing contemporary health systems, focusing on clinical leadership development strategies is of crucial importance. Empowering nurses to have control and influence over their practice is critical. This leadership role has to be undertaken within the complexity of healthcare systems. It is important that nurses undertake this role with credibility, competence and capability and interact with their colleagues respectfully and collegially.

In order to promote nursing leadership, a number of strategies have been implemented internationally. These include: clinical professoriate positions, clinical development units, practice development strategies, clinical leadership programs, and initiatives focusing on promoting evidence-based practice. The outcomes of these strategies are variable and commonly influenced more by local contextual and management factors rather than the value and the ethos of these programs. Regardless of the model undertaken, the following factors are critical: (1) increasing the voice of nurses at the decision-making table; (2) encouraging nurses' control over their practice; (3) promoting science and scholarship in nursing practice; (4) fostering an emphasis on patient outcomes and nurse-sensitive measures; and (5) working more effectively and efficiently in interprofessional practice environments.

An example of successful leadership models can be seen in the 'Magnet' programs, which have been widely implemented in the US and in several Australian sites and are currently being introduced in the UK. Magnet status is an award status administered by the American Nurses' Credentialing Center (ANCC), an affiliate of the American Nurses Association, to hospitals that satisfy a set of criteria designed to measure the strength and quality of their nursing. This ranges from a focus on specific nursing tasks to the quality of functional relationships within the organisation.

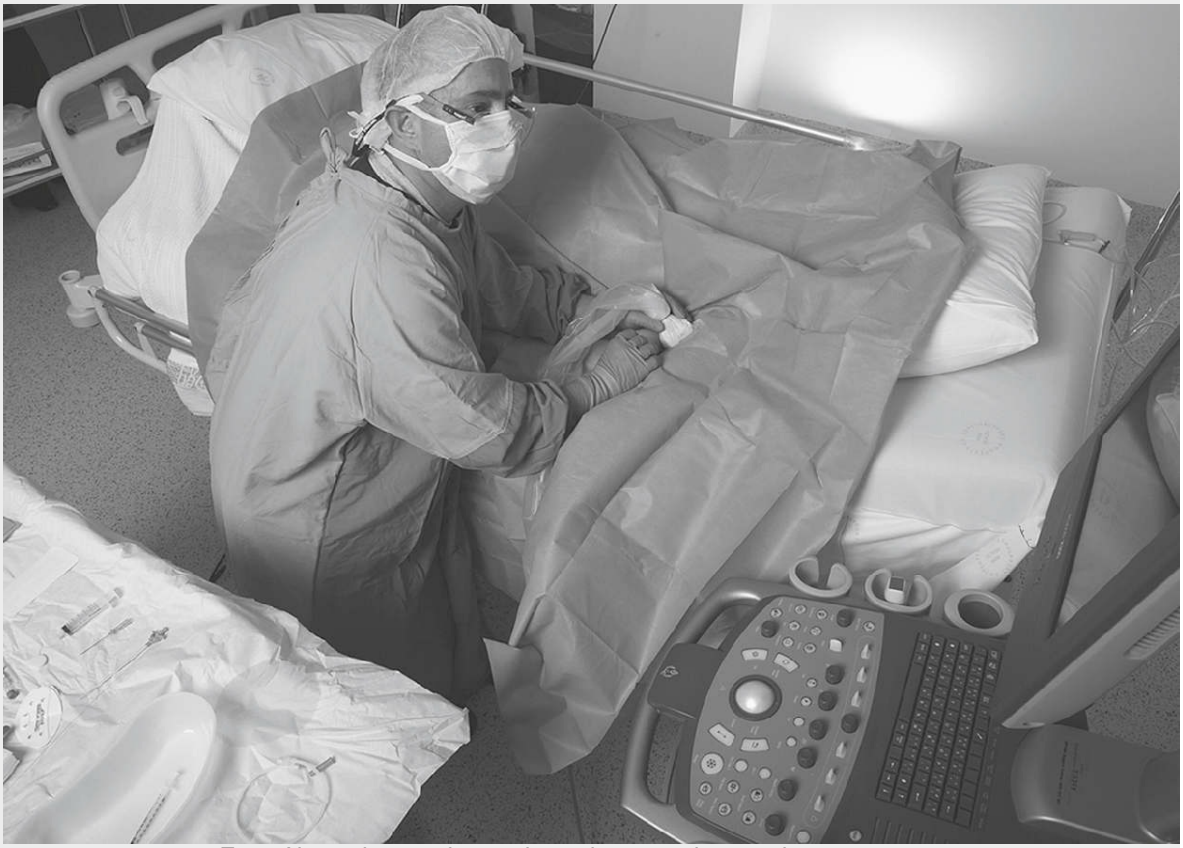
Many Magnet-accredited facilities have demonstrated optimal outcomes in respect of nurse-sensitive patient outcome indicators, such as pressure areas and falls. These programs have a strong influence across all levels of the organisation, from human resources to customer relations. Programs that employ such an approach are likely to have a greater chance of sustainable integration of strategies to promote clinical

leadership. Strategies that foster clinical leaders within interdisciplinary care models espouse and profile the important role of nurses in improving health outcomes (Kelly et al 2012, McCaughey et al 2020).

As you move through practice areas during your clinical placements, observe and critically evaluate strategies that you consider enabling for clinical leaders. Strategies that support a culture of collaborative clinical decision making, as well as an emphasis on education and reflective practice, are just some examples. See Box 11.1 for an example of an innovative nurse-led model of practice.

BOX 11.1 An innovative nurse-led model of practice

Nurse-led care is delivered using a comprehensive approach to patient care using the best available evidence. Advanced practice nurses work in collaboration with medical practitioners and offer a valuable contribution to the clinical care of acute and chronically ill patients. In the community there are many nurse-led models in chronic care, such as heart failure. There has also been an increase in the nursing role in procedural techniques, such as gastroscopy and vascular access devices. Often dedicated positions can lead to higher procedural volume and technical expertise. Increasing numbers of patients are requiring insertion of central venous catheters and as a consequence the rate of catheter-related bloodstream infections has increased. A series of studies has demonstrated a decrease in catheter-related infections and improved procedural and organisational outcomes through an increase in technical competence and a more integrated and comprehensive approach to patient care. Nurse leaders in Australia are leading the establishment of the evidence base for nurse-led vascular access devices through technical competence, expertise and monitoring of patient outcomes (Alexandrou et al 2014). This is an exciting approach to improving the quality and safety of patient care through nursing leadership and advanced practice.



Evan Alexandrou—advanced practice nurse in vascular access

PROFESSIONAL SOCIETIES AND ORGANISATIONS TO PROMOTE CLINICAL LEADERSHIP

Professional societies play an important role in terms of providing not only an environment of collegiality but also leadership, advocacy, mentorship and promotion of clinical excellence. These aims are achieved through the development of policy documents, publication of professional journals, conduct of scientific meetings and sponsorship of research and attendance at professional meetings. Some organisations serve the nursing profession broadly, focusing on an array of nursing issues, while others maintain a specialty focus. Examples of this in Australia are specialty groups such as the Australian College of Critical Care Nurses (ACCCN) and the Australasian Cardiovascular Nursing College (ACNC) and more generic organisations such as the Australian College of Nursing and, internationally, Sigma Nursing and the International Council of Nursing (ICN).

Sigma is an international organisation promoting leadership globally through scholarship, knowledge and technology to improve the health of the world's people.

Increasingly, professional nursing organisations are playing a role in terms of social advocacy and also mentoring and supporting nursing colleagues in developing countries. Particularly in situations of social disadvantage, nurses can play an important role in advocacy. What is increasingly apparent in a variety of settings is that a united

voice can be a powerful force. For example, the International Council of Nursing has taken strategic stances on issues such as ethical recruitment and women's health.

Take the time to view the information and resources on the following professional nursing organisation's websites presented in Box 11.2. Take time to look at professional development, available resources and opportunities for advocacy. These sites can also provide an opportunity to reach out to other nursing colleagues globally.

BOX 11.2 Examples of professional nursing and midwifery organisations

- Australasian College of Cardiovascular Nurses: www.acnc.net.au
- Australian College of Mental Health Nurses: http://www.acmhn.org/
- Australian College of Critical Care Nurses: www.acccn.com.au
- Australian College of Midwives: www.acmi.org.au
- Australian College of Nursing: www.acn.edu.au
- Australian College of Nurse Practitioners: www.acnp.org.au
- College of Nurses Aotearoa (NZ): http://www.nurse.org.nz/
- International Council of Nursing: www.icn.ch/
- Sigma: https://www.sigmanursing.org/

Leadership in evidence-based practice

The assessment of the cost-effectiveness and efficacy of nursing interventions and the relationship to patient outcomes is becoming increasingly important. Patient outcomes are largely dependent on implementing the best available evidence. You will hear a lot of discussion about evidence-based practice. This term refers to the implementation of the best available evidence within the context of the patient's needs, knowledge and belief systems, and using the clinician's expertise (Sackett et al 1996).

As a consequence, nurse leaders have to be increasingly focused not only on assessing the needs of the patients and their families but also on measuring outcomes (Conway et al 2019).

Outcome evaluation continues to be an important way in which nurses demonstrate their influence, not only to others but also to each other. This underscores that to be an effective clinical leader, you need to reach beyond charismatic attributes to implement clinical evidence and also evaluate the efficacy of nursing interventions. Clinical leaders

recognise that strategies to support research and scholarship are important to develop the evidence base for advancing nursing practice.

REFLECTION

What is the role of evidence-based practice in influencing health outcomes?

SIGNIFICANCE OF EXPERT CLINICAL PRACTICE

Expert clinical practice remains the foundation of the nursing profession's standing in communities. Clinical practice, informed by nursing science, is what makes nursing exceptional and unique, and is the key to our autonomous, professional practice. This underscores the importance of emphasising expert nursing within models of professional practice, education and research. Nursing roles such as clinical nurse specialists, clinical nurse consultants and nurse practitioners are crucial in advocating for expert nursing care. Internationally and even nationally, the names for these roles may differ, but the fundamental attributes are similar.

Nurses who function as leaders in these roles carry not only the privilege but also the professional responsibility to direct healthcare practices to optimise the health of the populations they serve and also to foster the professional development of their colleagues. This is achieved through promoting evidence-based practice, nursing scholarship and developing and delivering care that is tailored to the needs of patients and their families.

Take the time to review the code of conduct of peak nursing organisations, such as the Australian Nursing and Midwifery Council, the Nursing Council of New Zealand, the Thai Nursing Council and the Board of Nursing Philippines as well as the organisations in Box 11.2. The recommendations of these peak bodies should provide the blueprint for your professional actions and professional practice.

Looking to the future

In this chapter, we have discussed the challenges, strategies and progress for clinical leadership. Contemporary health systems are facing considerable challenges because of the increasing burden of chronic conditions, population ageing and fiscal constraints. Yet never before has the importance of nursing care and the evidence to support nursing interventions been so strong.

It is an exciting time to be embarking on a nursing career and never before has leadership been so crucial. As you begin your nursing career, it is important to try to turn challenges into opportunities. You will be working in rapidly evolving settings, and the practice environments you enter in the next few years are likely to be radically different on the tenth anniversary of your graduation. Focusing on the needs of patients and their families is important in shaping care models for the future and also in setting your compass for the future.

The test remains to influence nursing practice through positive and enabling leadership strategies and to develop innovative approaches to dealing with challenges facing current clinical environments. In order to achieve this, a system of mentoring,

career progression and succession planning in the clinical setting needs to be created and nurtured. Clinical and academic settings require a culture that develops innovation and fosters leadership potential.

CONCLUSION

At every level of an organisation, and regardless of whether nurses work in clinical, education or management streams, they have the potential to influence and direct patient care by exemplary leadership and excellence in clinical practice. The potential for nursing practice to influence clinical outcomes is an empowering and motivating concept. As you embark upon your nursing career, seek enabling clinical environments and mentors who will guide you along your professional journey. Taking the time to develop your interpersonal, communication and leadership skills will be critical for you having a productive and satisfying nursing career.

REFLECTIVE QUESTIONS

1. How can leadership in the clinical setting influence the quality and safety of patient care? Please identify both positive and negative leadership behaviours and styles and formulate a model for what you consider an effective leader to be.
2. What are nurse-sensitive patient outcome indicators? Identify an indicator from one of your clinical practice settings and consider how nursing leadership can influence the capacity to achieve optimal outcomes.
3. Identify a professional nursing organisation, and review their activities relating to leadership. Why are professional organisations important in formulating a professional identity and advocating for quality and safety in healthcare environments?
4. Can you identify some of your personal characteristics that will enable you to undertake a leadership position? Once you have identified these factors, what are some strategies for fostering your leadership from what you have read in this chapter?

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CHAPTER 12: INTEGRATED CARE AND MULTIDISCIPLINARY TEAMWORK

Jane L. Phillips, Claire Fraser and Louise D. Hickman

KEY WORDS

collaboration; communication; end of life; evidence; integrated care; interdisciplinary; team; multidisciplinary; nurses; palliative; approach; patient-centred; care; research; teamwork

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- describe and critically reflect on the unique role of nurses in providing integrated care, using the context of a palliative approach as an exemplar;
- describe the role of nurses in multidisciplinary and interdisciplinary teamwork;
- identify and describe the importance of communication in the context of effective delivery of integrated care to palliative patients and their families;
- discuss key practices and principles of a palliative approach, delivered within the context of an interdisciplinary team, across varied acute, residential and primary healthcare settings for different patient populations;
- critically appraise and apply the theory, research and evidence-based literature to integrated care in clinical practice and clinical decision making.

INTRODUCTION

This chapter provides nurses with guidance around their unique integrated care contribution as members of the multidisciplinary healthcare team. It explores integrated care in varied healthcare contexts including acute care, residential aged care, community and rural settings, using the delivery of a palliative approach as an exemplar. The chapter provides an overview of integrated care interventions with reference to multidisciplinary, interdisciplinary and transdisciplinary models. It emphasises the development of a suite of core skills to support integrated care, including the nurses' role in the interprofessional team, the importance of effective communication, key practices and principles of the best evidence-based palliative approach.

What is integrated care and why is it important?

Integrated care is a widely used term that has come to mean different things to different people (Armitage et al 2009). Integration lies at the heart of systems theory and is central to performance and organisational design (Lloyd & Wait 2006). Integrated care is defined as the management and delivery of health services so that patients receive a continuum of preventive and curative services, according to their needs, over time and across different levels of the healthcare system (i.e. community, acute care and residential aged care settings) (Lloyd & Wait 2006).

Rising population, climate change, urbanisation, technological advancements and globalisation are rapidly transforming our world and our communities. The collective impact of these changes requires effective communication and collaboration at local through to global levels (Institute of Medicine 2015). Interprofessional teamwork and collaborative practice is key to developing effective interventions within the healthcare setting. However, delivering on this promise requires health and social professions to interdependently meet the evolving challenges in delivering healthcare (Institute of Medicine 2015). It also requires a move away from professional siloing and hierarchical relationships and greater focus on collaboration. Interprofessional collaboration is critical to the effective organisation of the tasks required to provide specific patients and/or populations with the best evidence-based healthcare (Lloyd & Wait 2006).

The ultimate goal of integrated care is to increase efficiencies and improve patient outcomes by organising care in accordance with the patient's needs and preferences, and by reducing fragmentation (Shaw et al 2011). Integrated care is considered successful if it contributes to better care experiences and outcomes and lower healthcare costs (Hickman et al 2015, Institute of Medicine 2015). Emerging research suggests a patient's functional status and length of stay; a health professional's adherence to recommended practices and prescription of drugs; and the use of healthcare resources and costs can be positively impacted by interprofessional collaboration (Institute of Medicine 2015). However, the delivery of integrated care does require a greater emphasis to be placed on adequately preparing the next generation of health

professionals. Interprofessional and/or transprofessional education will assist in preparing undergraduate health professionals to enter the workforce with the skills and knowledge required to work collaboratively to improve care outcomes (Hickman et al 2015).

Integrated care evolved out of a need to reduce fragmentation by narrowing the traditional boundaries between health and social care, in order to: better meet the needs of a rapidly ageing population (many of whom are living with multi-morbidities and want to remain at home for longer); provide person-centred care; address the needs of society's most vulnerable members (many of whom have difficulty accessing care due to social isolation or other barriers); ensure more flexible care options; enhance care coordination; and reduce unnecessary healthcare waste, inefficiencies and costs.

Integrated care is best described as care that:

- is explicitly shaped by the patient's perspective and needs

- is linked to the needs of a specific patient population group as defined by the life cycle (i.e. adolescence and young people with mental health needs, older people living at home, or people with palliative care needs)

- is arranged to ensure continuity of care across time, which is provided by multiple providers (i.e. the patient's general practitioner (GP), community health nurses, specialist palliative care team and home care services) from different organisations (i.e. acute, community or aged care) and services (i.e. home nursing, diabetes education, wound care and community transport)

- requires inter-sectorial collaboration, whereby the healthcare service/team/nurse identifies and establishes linkages with the appropriate sector(s)/organisations (i.e. health, education and welfare) essential to improving the patient's care outcomes (Lloyd & Wait 2006, WHO 2008).

Integrated care does not mean all services required by an individual are combined into one 'care' package, but rather, the services required across various organisations and departments are coordinated and tailored to meet each patient's unique care needs. Integrated care is a way of coordinating the existing services to optimise patient outcomes. It has many forms and approaches including:

1. 'horizontal integration' which links relevant health and social services and required healthcare professionals together to optimise care at the patient level

2. 'vertical integration' which enables a person's care to be integrated across primary, community, acute care and tertiary healthcare services/settings

3. care integrated within one sector (e.g. mental health or palliative care), or across prevention and curative services

4. linking healthcare professionals and patients to optimise shared decision making and self-management

5. a 'whole of population approach' which requires the integration of public health, population-based and patient-centred approaches to optimise population health outcomes (Goodwin 2016).

Provision of integrated care that is flexible, personalised and seamless, which addresses the health and social needs of individual patients, requires significant change at the healthcare systems, health provider and patient levels (Lloyd & Wait 2006). However, implementing these changes is complex as it requires action at multiple levels, engagement of health professionals and managers, as well as a sustained commitment from healthcare organisations and policy makers (WHO 2008). These changes also challenge the traditional supply-driven models of care provision and require health professionals to have the foundation skills necessary for them to collaborate effectively with other disciplines involved in the person's care. If these challenges can be overcome, integrated care offers significant benefits for the patient, healthcare provider(s) and healthcare organisations, funding bodies and government (WHO 2008). The importance of taking action to improve patient outcomes across these three areas is best illustrated in the Chronic Care Model.

Chronic Care Model

Wagner's Chronic Care Model (1998) has been adopted by the World Health Organization (WHO) (2002). The Chronic Care Model encourages and supports patients to optimise their wellbeing by taking an active part in their care and working with health professionals who have the necessary resources and expertise. This model is designed to narrow the division between health and social care by centring care on the patient and their family's needs. Tailoring care to each patient's individual needs enables consumers to experience seamless and flexible care delivery (Lloyd & Wait 2006).

This model has several key elements that support high-quality, integrated care for people living with various chronic illnesses across care settings (see Fig. 12.1). Central to this model is the need for health professionals, healthcare teams and healthcare organisations to foster productive interactions between patients and their families by focusing on:

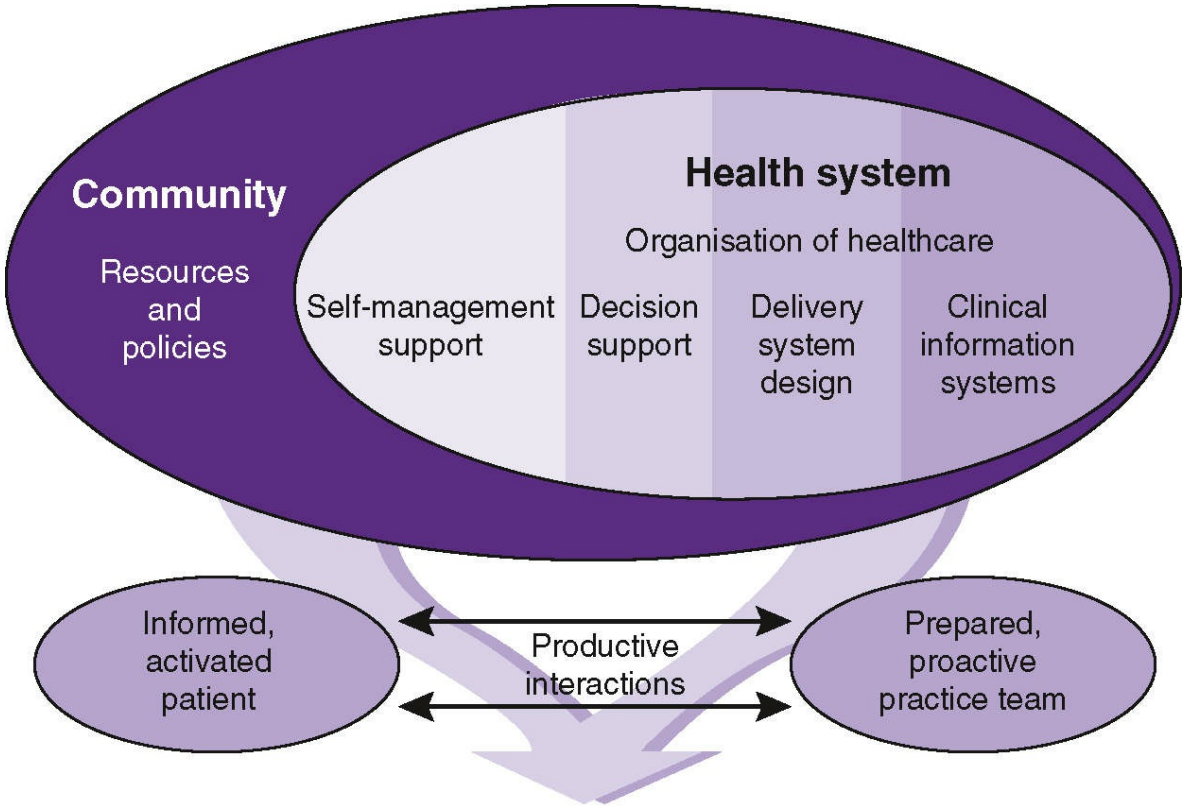

FIGURE 12.1 Chronic Care Model (WHO 2002).

- self-management support
- a healthcare delivery system
- decision supports
- clinical information systems
- organisation of healthcare
- community (WHO 2002).

Patient-centred care

Successful integrated care initiatives all focus on the design and delivery of patient-centred care, which is defined as: '… care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions' (Institute of Medicine 2001:48). A healthcare system that provides patient-centred care is focused on addressing the healthcare needs of patients

and provides the best evidence-based, cost-effective care. Optimal, patient-centred care occurs when the patient's care team:

- is committed to promoting and supporting self-care
- takes responsibility and is accountable for the care provided
- values clinical leadership
- supports timely sharing of patient information (i.e. has invested in appropriate infrastructure such as electronic health records that can be shared between providers and patient-held action plans)
- has good governance procedures and practices, and
- provides incentives to provide integrated care (Grant 2010).

Patient-centred integrated care is about ensuring the delivery of the right care, in the right place at the right time (WHO 2008). It is high-quality, flexible, needs-based, sensitive to individual and cultural differences, accessible to all, delivered in the home and community, and across general and specialist areas of the health system (WHO 2008). Excellent integrated multidisciplinary care is critical to improving care outcomes for people living with complex and/or chronic conditions and multi-morbidity. If provided early enough in a person's disease trajectory, it ensures planning and contributes to maximising the person's quality of life (WHO 2008).

MEAD AND BOWER'S PATIENT-CENTREDNESS CONCEPTUAL FRAMEWORK

Mead and Bower's (2000) patient-centred care conceptual framework (see Fig. 12.2) identifies five essential dimensions for achieving patient-centred care, namely:

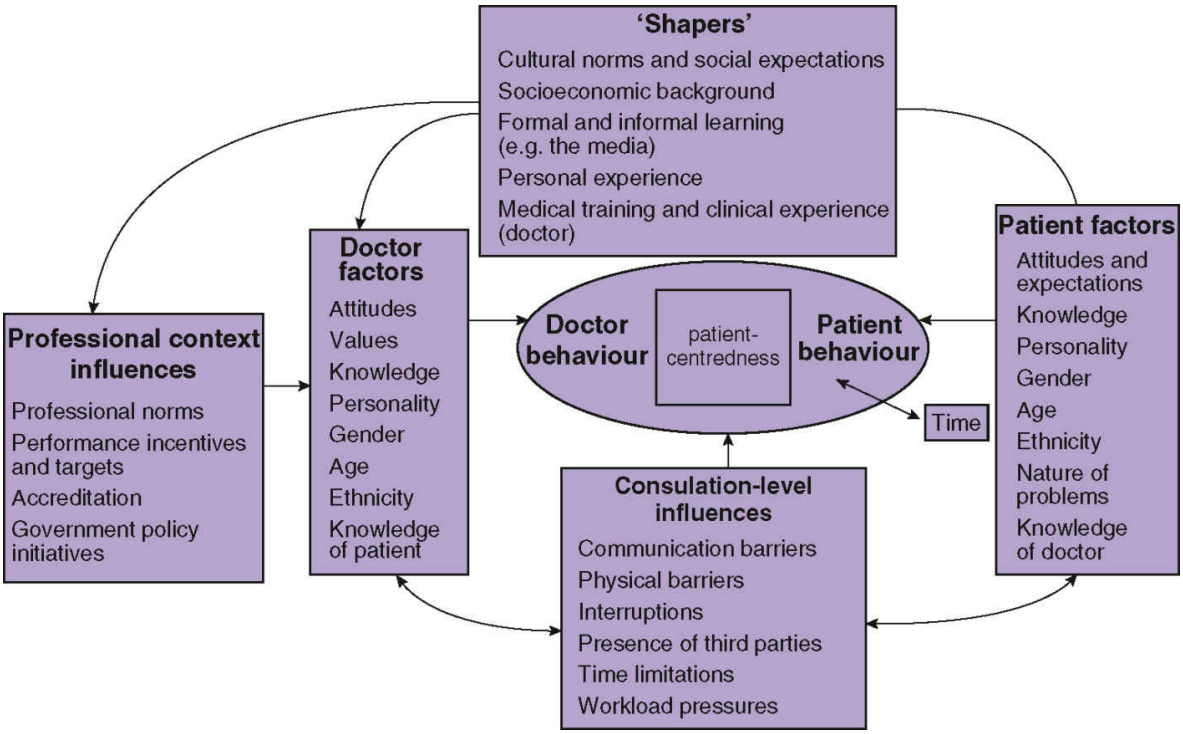

FIGURE 12.2 Factors influencing patient-centredness (Mead & Bower 2000:1104).

- biopsychosocial perspectives
- patient as person
- sharing power and responsibility
- therapeutic alliance, and
- 'doctor as person'.

This patient-centred framework identifies influencing factors relating to the patient, health professional, consultation, professional context and societal shapers. Luckett and colleagues (2013) have successfully applied Mead and Bower's framework (2000) to better understand the unmet integrated care needs of people living with cancer pain. In the process of applying this framework, they identified that it could be strengthened through the addition of two supplementary factors: caregiver, and systems- and service-level influences, both of which are highly relevant to the optimal delivery of integrated care, especially in the context of chronic and complex illnesses.

As an example, the importance of integrated patient-centred care for patients and families with palliative care needs is illustrated in Elizabeth's story.

What is the role of the nurse in multidisciplinary, interdisciplinary and transdisciplinary teamwork?

Optimal integrated care is dependent upon well-coordinated and effective teamwork involving multiple disciplines and services. There is good evidence that healthcare teams provide much better care than autonomous health professionals working in parallel and separate to one another (Bartel 2016, Crawford & Price 2003).

Integrated care teams can take many forms and operate in different care settings and with diverse populations (i.e. rapid response medical emergency teams, disaster response teams, chronic care teams, mental health teams, primary and/or acute care teams). The most effective integrated care team is non-hierarchical and utilises a collaborative, consensus building approach to care delivery, which is delivered via a multidisciplinary, interdisciplinary, transdisciplinary or collaborative community-led team, which is often preferred by Indigenous populations (Peake et al 2019). While these terms are often used interchangeably, they each have different meanings and applications (Choi & Pak 2006). An integrated care team is considered to be:

STORY

Part 1 Elizabeth's story: Integrated patient-centred care within a palliative approach

Elizabeth is a 67-year-old woman with Stage III lung cancer (advanced progressive incurable cancer) who has been living alone in a small rural town 180 kilometres from the nearest capital city since her husband died three years ago. She has a good network of friends and is in regular contact with her three adult children who live in the city and visit whenever they can. Elizabeth stayed with her adult daughter in the city while completing her course of palliative chemotherapy and radiotherapy. Over the past 6–8 weeks, she has lost 10 kilograms and developed a persistent cough, night sweats and back pain.

Her GP is very supportive and has arranged a medical oncology review for Elizabeth and plans to see her weekly to manage her medications (analgesics and aperients). The GP has collaboratively developed a care plan with Elizabeth that addresses her care needs and concerns. The GP has also arranged for Elizabeth to see the practice nurse to establish a relationship and to help her complete her advance care plan, which they intend to share electronically with other members of Elizabeth's care team and her family. The GP has encouraged Elizabeth to discuss this plan with her adult children and medical oncologist when she next sees them.

At this stage, Elizabeth's priorities are to: remain at home for as long as possible; not be a burden to her adult children; be comfortable and as active as possible; and put her affairs in order. She is still independent and reluctant to accept additional assistance but is reassured that she can have home care assistance when she is no longer able to manage. She has agreed to meet the community nurses before she is too unwell so they

can monitor her progress and establish a relationship. She is comforted by the fact that she has a network of friends who are willing to assist her to stay at home and when she can no longer manage at home, her GP will arrange for her to be admitted to the local hospital for end-of-life care.

Summary

Elizabeth's circumstances demonstrate that not all patients with palliative care needs require the input of a specialist palliative care team. However, patients like Elizabeth will need well-integrated patient-centred palliative care provided by their usual primary care team (general practitioner, community nurses, home care worker, family, friends and neighbours). Elizabeth will only need a referral to the specialist palliative care service if her usual care team is unable to effectively manage her symptoms (Palliative Care Australia 2005, Quill & Abernethy 2013).

Reflective Questions

1. Describe and critically reflect on the unique role of the nurse in providing integrated care within Elizabeth's primary care team.

2. How could the nurse ensure effective communication in the context of effective delivery of integrated care for Elizabeth?

3. Using Mead and Bower's framework, describe the patient-centred care approaches that apply to Elizabeth's situation and needs, within the context of an interdisciplinary primary care team.

4. How can a nurse effectively address Elizabeth's physical, psychological, social and spiritual needs, and those of her significant others?

- **multidisciplinary,** if it is composed of members from more than one discipline (hence multiple) who work on addressing a patient problem in parallel or sequentially without challenging or going outside of their disciplinary boundaries (Choi & Pak 2006). These team members usually work independently to assess, plan and formulate goals for the patient. They interact formally at a multidisciplinary team meeting. These teams are usually hierarchically organised with a designated team leader. While working collaboratively with one another, these health professionals act autonomously. The cancer treatment team that meets to determine the optimal course of cancer treatment for each woman diagnosed with breast cancer is a good example of a multidisciplinary team.

- **interdisciplinary,** if it is composed of a group of professionals from several different disciplines who are trained to use different tools and apply

different concepts, working interdependently in the same care setting, and who interact both formally and informally to achieve a common goal (Choi & Pak 2006, Newhouse & Spring 2010). Interdisciplinary teamwork is defined as a dynamic process between two or more healthcare practitioners who use a concerted approach to assess, plan and evaluate patient care, using open communication, shared decision making and interdependent collaboration (Xyrichis & Ream 2008). Each team member contributes their own professional expertise but collaborates to interpret findings and negotiate priorities to develop an agreed plan of care for the patient. These members exhibit collaborative communication and interdependent practice (Services for Australian Rural and Remote Allied Health, n.d.). In this team, there is reciprocal interaction (hence 'inter') between the disciplines, leading to a blurring of disciplinary boundaries in order to optimise patient care outcomes (Choi & Pak 2006). Interdisciplinary teams are considered to have a heightened ability to enhance and promote cooperation, coherence, shared responsibility, internal organisation and communication (Junger et al 2007).

- **transdisciplinary,** if it involves a range of stakeholders and disciplines outside of health who transcend (hence 'trans') disciplinary boundaries and share role functions to optimise care outcomes. In addition to collaborating, team members entrust, prepare and supervise the sharing of disciplinary functions while retaining ultimate responsibility for services provided in their place by other team members (Choi & Pak 2006). The emphasis is on sharing team responsibilities. A transdisciplinary team is based on the premise that one person can perform several professional roles by providing services to the patient under the supervision of individuals from other disciplines (Columbia University n.d.). It requires cross-training and flexibility in accomplishing tasks. Transdisciplinary teams are most commonly observed in environments where flexibility with roles and responsibilities is required, such as in rural, remote and humanitarian healthcare (Services for Australian Rural and Remote Allied Health n.d.).

What attributes do nurses require to be effective integrated care team members?

It is challenging to define optimal team-based healthcare, including specific guidance on the best structure and functions for teams, because of the heterogeneity of their focus, tasks, patient types and settings. However, as health professional education advances, there are opportunities to improve interprofessional learning and practice whereby each discipline learns with, from and about each other (Bridges et al 2011). While there is not necessarily a recipe on how to create an effective integrated care team, a recent review has identified five personal values or attributes that members of high-performance teams exhibit:

STORY

Part 2: Elizabeth's interdisciplinary palliative care team

We return to Elizabeth's story some three months later …

Elizabeth is still keen to remain in the community, but she is getting weaker and more breathless, which has made it harder for her to get out of the house and into her garden. During the past fortnight, she called the ambulance several times at night with an exacerbation of breathlessness and associated anxiety. Also, on several occasions she acknowledged to her daughter that she felt she was becoming depressed and more socially isolated. After several discussions with her community nurses and GP, Elizabeth agrees to a referral to the specialist palliative care team.

The interdisciplinary specialist palliative care team focuses not only on Elizabeth's physical needs but also assesses her psychosocial and spiritual needs. With Elizabeth's permission, the palliative care social worker contacts her daughter, who has her own concerns and expresses frustration that her mother won't move to the city to be nearer her adult children who could help her and so she can spend more time with her 10 grandchildren (aged 3 months to 15 years).

The complexity of Elizabeth's care needs requires input from a variety of different disciplines, i.e. medicine (specialist palliative care physician and GP), nursing (specialist palliative care and community nurse), allied health (occupational therapist for home modifications and mobility aids and physiotherapist for breathing exercises), a psychologist (psychological support), pastoral care (spiritual support) and volunteer (companionship, practical and emotional support) and application of evidence from different theories and models (i.e. biological, pharmacological, social, psychological and ethical) (Bartel 2016, Hui et al 2016). In Elizabeth's situation a specialist interdisciplinary palliative care team is most appropriate because it enables:

- the team to draw upon each other's expertise and wisdom, especially as one discipline will not possess all of the attributes required to manage all of Elizabeth's and her daughter's palliative care needs

- different team members to share information and work interdependently
- leadership to be task dependent
- the team to cover for each other in terms of the generalist patient support role
- the team to respond rapidly to the patient's and family's changing needs, especially in a time of crisis (Crawford & Price 2003).

An interdisciplinary team approach to care is enshrined in the philosophy of palliative care, its standards and care practices. The WHO definition acknowledges that palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems (WHO 2003). A recent rapid review and meta-synthesis has identified that integrated interdisciplinary teamwork is one of the six essential elements of effective palliative care for people with palliative care needs who wish to spend as much time as possible at home (Seow & Bainbridge 2018).

Reflective Questions

1. Describe the role of the nurse within the interdisciplinary team.

2. How can the principles of a patient-centred palliative care approach support integrated care?

3. How can nurses ensure that integrated care in clinical practice and clinical decision making is underpinned by best evidence-based practice?

REFLECTION

Effectively addressing the holistic needs of palliative patients, including their physical, psychological, social and spiritual needs, as well as those of their families, is only possible through the coming together of multiple disciplines.

Describe the strategies the interdisciplinary care team ought to adopt to ensure that Elizabeth receives the best evidence-based, patient-centred palliative care tailored to her needs and preferences.

- **Honesty:** High-performance team members place a premium value on being transparent about team aims, decisions, mistakes and uncertainty. An open and respectful communication style enables the team to focus on continued improvement and helps build trust (Mitchell et al 2012).

- **Discipline:** In high-performance teams, individual team members are committed to doing the best they can within the scope of their role and allocated time. They are disciplined in seeking out and sharing new information that will improve the team performance, even if sharing these ideas may make them or others uncomfortable. This discipline prevents the team from deviating from their mission or standards, while being open to new methods that will strengthen their capacity to deliver (Mitchell et al 2012).

- **Creativity:** High-performance teams are composed of members who are excited by the possibility of tackling new and/or emerging problems creatively. They use unanticipated adverse events and/or sub-optimal performance or outcomes as an opportunity to learn and to improve.

- **Humility:** Members of high-performance teams recognise the value of multiple perspectives and respect members with different types of training and acknowledge that everyone makes mistakes. They rely on each other to avert and mitigate against failures, regardless of their role within the team (Mitchell et al 2012).

- **Curiosity:** High performance team members are reflective. They use the insights from their daily encounters to grow and continuously improve their own practices and team functioning (Mitchell et al 2012).

In addition to these personal values, effective interdisciplinary care is also underpinned by the following key team principles:

- positive leadership and management attributes

- communication strategies and structures

- personal rewards

- training and development

- appropriate resources and procedures

- appropriate skill mix

- supportive team climate

- individual characteristics that support interdisciplinary teamwork

- clarity of vision
- quality and outcomes of care
- respect (Nancarrow et al 2013).

Partnering with patients and families and developing shared goals

Placing patients and families at the centre of the care team ensures that their needs and wishes inform all care decisions. Actively partnering with patients is a defining element of patient-centred care and essential for shared decision making. When care is patient-centred, the team, including the patient and family, work collaboratively to establish shared goals that reflect the patient's needs and priorities; that are clearly defined, and are shared with and understood by all members of the team (Mitchell et al 2012). This approach ensures that the patient truly owns the care plan and the care is patient-centred. Involving patients in care decisions is not necessarily new, as the concept of informed consent is built upon the legal and ethical notion that patients have a right to be involved in decisions that affect their health and wellbeing (Mitchell et al 2012).

There is good evidence that people who are involved in healthcare decisions have better care outcomes and more cost-effective care (Greene & Hibbard 2012). Despite these positive outcomes, there are many barriers that prevent health professionals from actively partnering with patients and families, such as: patients being ill-prepared to effectively partner with health professionals; power imbalances; poor communication; payment structures that reward volume over value; and a poorly prepared health workforce (Mitchell et al 2012). Many of these barriers could be addressed through health service reforms, such as restructuring the healthcare culture and practices, strengthening patient–clinician–team communication, building effective healthcare teams and promoting the use of knowledge sharing and self-management tools (Mitchell et al 2012).

Developing collaborative team practices

Regardless of the team's focus (i.e. chronic care, palliative care, primary care and/or acute care) and model (i.e. multidisciplinary, interdisciplinary or transdisciplinary), collaboration between team members is an essential element for integrated care (San Martin-Rodriguez et al 2005). However, collaboration is a complex phenomenon, which requires individual team members and/or the service to forgo a competitive approach and be prepared to negotiate to optimise patient care outcomes.

Collaboration requires team members who are: 'competent', 'confident' and 'committed' (Henneman et al 1995). Fostering collaborative practices is challenging, largely because of the numerous systemic (conditions outside of the organisation, such as cultural, social, educational and professional systems), organisational (conditions within the organisation, such as team structure, philosophy, resources and

administrative supports) and interactional (interpersonal relationships with other team members, such as willingness to collaborate, trust, communication and mutual respect) factors at play (San Martin-Rodriguez et al 2005).

Effective interdisciplinary teamwork in primary and aged care settings is enhanced when there is effective organisational leadership, good team relationships, appropriate organisational processes and structures, good communication and appropriate physical support (Al Sayah et al 2014, Nazir et al 2013). There is evidence that team collaboration is enhanced at the micro level through collegial development of integrated care practice manuals that define each team member's role in order to minimise duplication and to facilitate delegations and fostering interprofessional education sessions on collective decision making and effective teamwork (San Martin-Rodriguez et al 2005).

Interprofessional education is crucial as the provision of collaborative integrated care demands the development of new competencies (knowledge, skills and attitudes) (San Martin-Rodriguez et al 2005). Increasingly, undergraduate nursing, medicine and allied health students' courses are adopting interprofessional education as a means to prepare students for collaborative team practice. Optimal interprofessional practice occurs when members of different health and social professions learn together, in an interactive environment, with an explicit aim of fostering collaboration between the participants (Reeves et al 2013).

Creating clearly defined roles

The creation of clearly defined roles ensures the knowledge and skills that individual team members have from different disciplines are effectively harnessed (see Part 3 of Elizabeth's story below). Australian GPs have suggested that establishing clearly defined roles is crucial if the patient is to receive optimal palliative care from an interdisciplinary team (Herrmann et al 2019). Differentiating the function of each team member, their responsibilities and accountabilities, enables the integrated care team to take advantage of the division of labour and accomplish more than the sum of its parts (Mitchell et al 2012). Achieving this requires team agreement about how discipline-specific roles and responsibilities will be optimised to improve care outcomes for individual patients and families (Mitchell et al 2012). It also requires an understanding of the legal parameters of each discipline's scope of practice and the reimbursement models that govern fee-for-services clinicians, such as physicians and GPs.

Despite the need for clearly defined roles within the integrated care team, some flexibility is also required, especially with changing needs, clinical circumstances and unanticipated absenteeism. Being able to take on additional team responsibilities at short notice requires nurses to be flexible, communicate effectively and have an understanding of the background, skill sets and responsibilities of other team members and be prepared to take on additional duties within their scope of practice (Mitchell et al 2012).

STORY

Part 3 Creating clearly defined roles to manage Elizabeth's care needs

Defining the roles to manage Elizabeth's care needs requires a number of considerations. A good starting point is to view care through Elizabeth's and her daughter's eyes, as it helps to build mutual trust (Mitchell et al 2012).

A family meeting involving Elizabeth, her daughter and the interdisciplinary specialist palliative care team may be required to collaboratively develop an appropriate care plan and put the necessary strategies in place to address Elizabeth's increasing symptom burden (breathlessness and anxiety), fragility and wish to remain at home for as long as possible, while balancing her daughter's desire for her to relocate to the city. Given these contrasting goals, the team will be called upon to apply their well-developed negotiation and conflict management skills so that they can optimise care outcomes for both Elizabeth and her daughter. This meeting is also an opportunity to clearly define the roles each team member will take on, everyone's expectations and to seek agreement on the process for shared decision making (Mitchell et al 2012).

Creating clearly defined roles to manage Elizabeth's care needs requires different considerations given the more sporadic and often shorter-term engagement of palliative care patients and their families as active team members. The distribution of team responsibilities will also be determined, taking into consideration how to effectively use the capabilities of different team members (i.e. the nurses, palliative care physician and GP, the occupational therapist, physiotherapist, dietician, social worker, pastoral care and/or volunteers and other community services/supports) to maximise care outcomes for Elizabeth and best resource utilisation (Mitchell et al 2012).

Foster mutual trust

Individual team members' commitment to upholding the values of honesty, discipline, creativity, humility and curiosity build the trust required for the creation of a high-performance team essential for constructing more patient-centred and effective healthcare delivery (Mitchell et al 2012). Molyneux (2001) and San Martin-Rodriguez and colleagues (2005) outline that a non-hierarchical, balance of power between team members and a positive, enthusiastic nature, flexibility, motivation and commitment are essential to creating an open and sharing environment, which promote team trust. San Martin-Rodriguez and colleagues (2005) and Youngwerth and Twaddle (2011) identified that interpersonal relationships fostered on mutual trust and respect promote cooperation, information sharing, collaboration, cohesiveness and reinforce role appreciation.

Mutual trust creates an environment that allows for continuous learning and ensures team norms are upheld. However, it requires team leaders who are committed to creating a safe and trusting environment where everyone has a voice, regardless of role, and that members' ideas and concerns are welcomed and addressed. Healthcare organizations can foster the establishment of mutual trust by investing in strategies that enable the team to get to know one another at a personal level, embedding the personal values for high-functioning teams into the organisational recruitment and selection processes, and building the team's communication, negotiation and conflict resolution capabilities (Mitchell et al 2012).

Effective communication

Mutual trust and effective communication are interlinked and are essential elements of integrated care. Along with trust, the quality and timeliness of communication between members of the healthcare team is consistently cited as one of the main factors impacting on their experiences, satisfaction and the success of integrated care (Stephenson et al 2015). Inadequate interdisciplinary team communication across and within care settings contributes to clinical errors, inefficient care delivery and compromises patient safety. An effective integrated care team prioritises and continuously refines their communication skills and practices. These teams support candid and complete communication using consistent communication channels, which can be accessed by all members and across care settings (Mitchell et al 2012). In the digital age, communication is not just limited to face-to-face and written communication but also to telephone, email, text messages and electronic health records (Mitchell et al 2012). The establishment of good communication systems and mechanisms to support the timely transfer of information are crucial for team functioning and to optimise care outcomes. This makes investing in information technology infrastructure and support, including an electronic health record system, an important integrated care priority (Al Sayah et al 2014).

The adoption of standards, policies and interprofessional protocols, combined with interdisciplinary team meetings, are all strategies designed to support effective communication (San Martin-Rodriguez et al 2005). Setting a high standard for team communication, ensuring consistent, clear and professional communication among team members is essential (Mitchell et al 2012). Integrated care teams are encouraged to speak clearly and succinctly, drawing upon their professional knowledge but avoiding jargon, discuss verifiable observations rather than personal opinions and actively listen (Mitchell et al 2012). The use of questions encourages patients and families to contribute while modelling to others the salient points to be considered. Effective team communication requires a commitment to continual reflection, and identifying and testing strategies for improvement (Mitchell et al 2012). It also requires an organisational commitment to investment in building team members' communication capabilities.

Authentic collaboration

Integrated care requires persistence, continuous monitoring and improvement practices, to address the elements that appear to deteriorate over time and impact on the team's capacity to provide integrated care, such as inflexibility and preservation of autonomy, and provider engagement and useability of computer systems (Stephenson et al 2015). The domains of successful integrated care programs that appear to improve over time are access and coordination of care, flexibility and autonomy, provider engagement, teamwork and a development of professional identity, skill development, information transfer and workload and time efficiency (Stephenson et al 2015).

REFLECTION

- Collaboration is a complex, voluntary and dynamic process that is dependent upon individual team members having the necessary leadership, communication and relationship-building skills (Barrett et al 2007).

- Respecting and trusting other members of the interdisciplinary team are key elements of all effective collaborations.

- As the discipline that spends the most time with patients and their families, nurses are ideally positioned to take a lead role in coordinating and facilitating communication between other team members:

- Having clearly developed protocols (Bentham et al 2015) and utilising validated screening and assessment tools helps optimise team communication (Hosie et al 2014, Phillips et al 2006)

- Communicating the nuances of the patient's care needs to other members of the team and careful documentation of the details, even when time is limited, is essential for good care outcomes (Crawford & Price 2003)

- In addition to having well-developed clinical skills (i.e. screening, diagnostic and intervention skills), integrated care requires an ability to use electronic medical record and/or registry systems (Bentham et al 2015)

- Understanding the multiple factors that impact on interdisciplinary team functioning helps nurses recognise and address any potential barriers to providing integrated care.

The benefits of integrated care

The benefits for the patient, healthcare provider and organisations of integrated care are summarised below:

- **Patient:** For the patient, care is coordinated and focused on long-term wellbeing and not episodic care. Care is provided by well-informed health professionals, who have an understanding of the patient's condition(s) and care needs, and communicate effectively with other members of their care team. The patient experiences a seamless, smooth and easy-to-navigate healthcare system with shorter waiting times, better outcomes and quality of life (WHO 2008).

- **Healthcare providers:** Working collaboratively with other members of the

integrated care team ensures that all of the separate technical/care services are provided in a coordinated and efficient way so the patient gets the right care, in the right place at the right time (Xyrichis & Ream 2008). By working collaboratively with other health professionals from different fields, the integrated care team is able to coordinate services and tasks across traditional professional boundaries (Lloyd & Wait 2006).

- **Organisations:** There is a potential reduction in healthcare costs due to less duplication of medical tests (i.e. pathology and radiological tests), better information sharing and a reduction in avoidable or unnecessary hospitalisations. Integrated care requires all of the necessary processes, policies and funding arrangements to be in place. Effectively managing strategic alliances and partnerships between different institutions helps optimise care outcomes and results in better use of scarce health resources (WHO 2008).

CONCLUSION

Collaboration between health professionals improves healthcare outcomes and enhances patient and professional satisfaction while reducing healthcare costs. This chapter has explored integrated care in varied healthcare contexts including acute care, residential aged care, community and rural settings. Exemplars using the delivery of a palliative approach were provided as an overview of integrated care interventions that have improved the quality and safety of the process of care for patients in the last year of life and that of their families. Integrated care is defined as the management and delivery of health services so that patients receive a continuum of preventive and curative services, according to their needs, over time and across different levels of the health system.

Integrated care aims to improve the connection between health and social care to better meet the needs of different populations. The defining features of integrated care are: i) the organising principle of service delivery is the patient's perspective; ii) it is linked to the needs of a specific patient population group as defined by the life cycle; iii) it involves the arrangement of multiple providers; and iv) it often requires inter-sectorial collaboration. Integrated care does not mean that all of the services required by an individual are integrated into one 'care' package, but rather that the services required across various organisations and departments are coordinated and tailored to meet each patient's unique care needs. The benefits at the patient and healthcare provider levels are numerous. As the largest health professional group, nurses have a unique role in providing integrated care within multidisciplinary and interdisciplinary teams.

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CHAPTER 13: TECHNOLOGY AND PROFESSIONAL EMPOWERMENT IN NURSING

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KEY WORDS

advocacy; caring; clinical; empowerment; healthcare; knowledge; person; professional; values; radical nursing; skills; technology

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- explain the importance of technology for nursing practice and skills development;
- describe characteristics associated with technology that are important for patient-centred care;
- understand implications of technology for nursing care with specific reference to advancing professional empowerment;
- apply principles and values important for fostering excellence in nursing practice when associated with technology.

INTRODUCTION

This chapter considers the contribution and importance of technology with specific reference to the provision of patient-centred nursing care and professional empowerment. Principles important to understanding technology are outlined as are the implications of technology for provision of nursing care, including guiding principles and values important to appropriate integration and translation of new technology into clinical practice. Technology is a fundamental aspect of clinical practice, but it must be understood adequately to address the many challenges it presents to provide safe quality care.

Nursing and technology

Technology influences the practice of nursing both from the perspective of what we do and how we understand ourselves as practitioners. Nurses talk about technology, develop skills and knowledge to apply technology, interpret the health of our patients through technology, organise the workplace with the assistance of technology, praise the qualities of the latest advances and sometimes worry about loss of human contact and work in a changing workplace. Technology is used, for example, to deliver accurate treatment even at a distance, to hold water, to digitise care through electronic medical records (EMR) and to observe the internal workings of the human body. Technology advancement is associated with a shorter length of hospital stay, efficiency in care delivery, changing skills and knowledge, alteration to employment patterns, specialisation and standardisation of care. These outcomes of technological development combined with increasing legal liability can often create a sense that our practices are focused on conformity, automation, safety, predictability and a striving for order.

Technology is significant to the history and future of nursing, especially because we are part of the daily functioning of technological activity. Prior to the twentieth century, technical knowledge and skills were developed by trial and error, and were passed down through generations via a practical and oral culture. Nurses relied on experience, intuition and faith. Technical skills included magical and aesthetic components that equated with moral and psychic life. Nursing practice relied less on scientific knowledge, critical thinking, problem solving and explanation than on a personal and intuitive understanding developed and refined through practice.

The rapid growth of scientific and technological knowledge in the twentieth century brought about enormous changes for nursing and healthcare, and technology has figured prominently in that development as an influential partner to our practice. Rinard (1996) noted that in modern nursing there have been three key periods of change that have been significantly influenced by technology. The first period was 1950–65 and was characterised by new medical techniques and a significant introduction of pharmaceuticals to care. The second period was 1965–80 and was associated with greater use of sophisticated/automated technology and the emergence of new

knowledge and specialisation. The third period was from 1980–90 and was associated with increasing technical control, streamlining and prediction of care as demonstrated by the emergence of automated pumps and monitoring equipment. A more recent fourth period, not identified by Rinard (1996), could be explained as a period of rapid information retrieval and computerised healthcare leading to rapid information access and care delivery at distance (Barnard & Sinclair 2006, Sandelowski 2000).

Emerging and future technology developments in healthcare will be numerous and will include greater access to medical record data for integrated healthcare records, decision support software and information, and new smartphone applications along with wearable technologies. There will be greater information access that will lead to further networking for practitioners and patients as well as support groups, and wireless sensors for monitoring at distance in developed and developing countries. Diagnostic test results will be more rapidly available and will reduce the cost of healthcare, as well as facilitate remote care away from large organisations into lower-cost settings. Genetics and DNA sequencing are now beginning to assist tailormade treatments for people and genetic information will increasingly guide the uptake of evidence-based treatments, in an environment, however, where the therapeutic effects of antibiotic therapies will be declining due to increasing antimicrobial resistance. Finally, micro-monitoring and robotic assisted care and surgery will change the way care is delivered, the way we and others think about nursing as a profession and the resources available for healthcare delivery (Monteiro 2016).

Robots have a number of key features that include, importantly, the ability to make autonomous decisions and operate in real-world environments without external control. Robots will increasingly become self-determinate, learn from mistakes and exhibit some degree of designed emotional and intellectual engagement; they will soon start to talk like and act like a nurse. Already there is increasing application of early developments in robotics, especially in aged care. Robots can pick up and place a patient into bed (Care-O-Bot; RI-MAN), interact with patients to educate and provide guidance (Nurse-Bot), and feed patients who are unable to do so themselves (MY SPOON). There are also companionship robots such as JustoCat or PARO which is a therapeutic seal robot used in dementia care (Banks et al 2008, Beedholm et al 2015, Broadbent et al 2016, Gerling et al 2016, Joranson et al 2015, Joranson et al 2016, Pu et al 2019, Robinson & Broadbent 2016). Sharts-Hopko (2014) identifies a number of potential robot applications in healthcare that include cleaning, feeding patients, preparing food, attending at an emergency, bathing, providing emotional support, medication administration, ambulating and moving patients, driving a car and guiding people as they walk around. Many of these activities are nursing related and robot involvement will impact directly on our practice (Salzmann-Erikson & Eriksson 2016).

Technology significantly influences our work, not only in terms of tools, machinery, automated equipment, etc., that we use, but also how we do things, how we organise ourselves as nurses and what we value. In fact, over 20 years ago, Cooper (1993) warned that the process of automation and technological change had advanced to such an extent that many areas of nursing practice had come to be defined by technology. For example, the haemodialysis machine is associated with renal nursing and the ventilator

is associated with critical care nursing. The warning has been confirmed further through, for example, the emergence of competency-based education and practice, which is linked directly to the safe integration and use of technology(ies). But regardless of whether the observations of Cooper are proving to be entirely accurate, it is acknowledged widely that nurses in all specialties are required to use a significant amount of technology and accept increasingly complex and diverse roles and responsibilities associated with its ongoing importance in healthcare (Barnard & Locsin 2007, Daly et al 2009).

Interpreting technology

The word technology (tech-nol-ogy) refers to the practical arts, specific implements and the knowledge and/or activity of a group (i.e. technologist). Technology as a phenomenon is subject to varied and sometimes inadequate explanation in nursing and understanding is influenced by social status, culture, gender and politics (Barnard 2002, Rinard 1996). Technology is in fact more than the sum of the things we use in healthcare. It has characteristics that include the development of skills and knowledge and also alteration to meanings and values (Barnard 2016, Bull & Fitzgerald 2006, Pacey 1999, Winner 2003).

One way to portray and interpret technology is as three concentric circles (see Fig. 13.1). Concentric circles highlight the characteristics that together emphasise a character-ological interpretation of the phenomenon. That is, the concentric circles portray how the parts of our practice can be interpreted in relation to the fundamental characteristics of technology. The interpretation is useful because it focuses our attention on not only the 'things we use in nursing' (located at the centre), but also their relations to other characteristics.

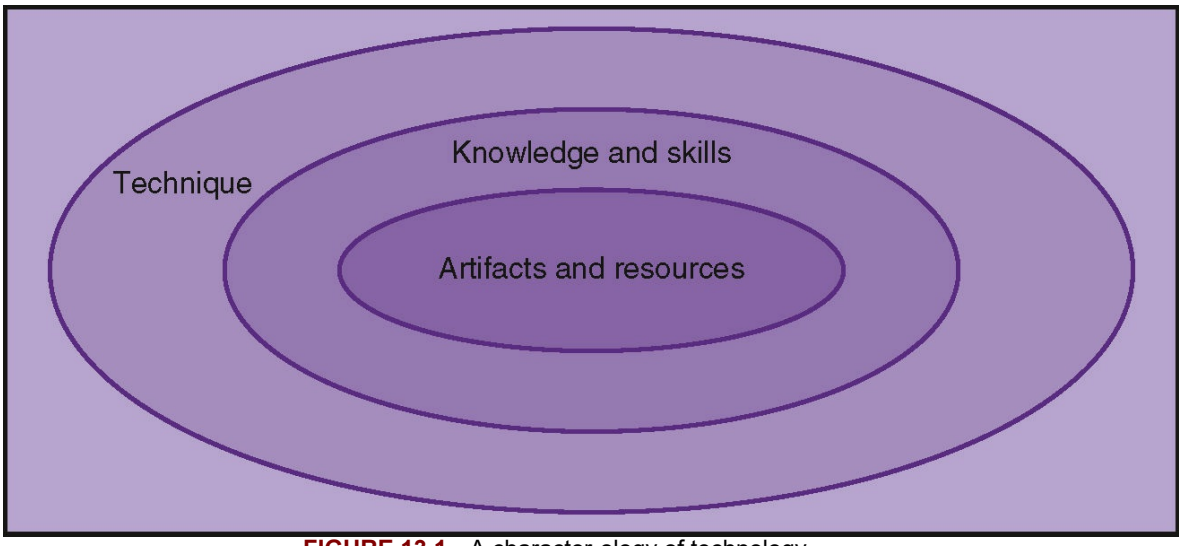

FIGURE 13.1 A character-ology of technology

ARTIFACTS AND RESOURCES

The smallest and central concentric circle depicted in Fig. 13.1, artifacts and resources, is technology at its most obvious and refers to the integration, use and application of the 'things' of nursing. We are required to include increasing amounts of technology in daily practice, and it is useful to clarify the various types of technology that are often found in our practice. We use simple, sophisticated, old, new, unique and commonplace technologies that continue to evolve in design and application. It can be observed that there are at least 12 different types of technologies that include clothes (e.g. shroud, pyjamas), utensils (e.g. bedpan, kidney dish), structures (e.g. hospital ward, isolation room), apparatus (mechanical hoist, wheelchair, trolley), utilities (e.g. electricity, gas), tools (e.g. urinary catheter, syringe), resources (e.g. pharmaceuticals, sterile dressing), machines (e.g. intravenous infusion pump, ventilators), automata (e.g. computer, refrigerator, wearable monitoring devices), tools of doing (e.g. nurse's watch, stethoscope, digital display), objects of art or religion (e.g. nurse's uniform) and toys/games used for diversion and distraction (e.g. augmented reality games, internet-based game, smartphone apps).

Although technologies are new, increasingly accurate and powered by utilities such as electricity, it is worth noting that there is also a lot of simple technology that remains fundamental to daily care (e.g. a shower chair, a stethoscope and a bedpan). Artifacts and resources assist to enact complex assessment and treatment, while supporting us to meet the daily needs of each patient. They include things we hold in our hand, pharmaceuticals we dispense to people, volumetric pumps we use to assist treatment delivery and various noises and visual stimuli observed on screens and digital displays.

While we could debate what technology is specific only to nursing, for our purposes we will include any technology that we use and/or claim to be fundamental to our daily practice. However, in stating this, it must be recognised that a lot of commonplace and simple nursing technology is not acknowledged as significant. This could include items such as the bedpan, a critical piece of nursing technology (Barnard & Locsin 2007). That is, much of our important technology lacks recognition by nurses both in clinical practice and in nursing literature. The reasons for the lack of acknowledgement are speculative, but include emphasis on new and sophisticated technology, a tendency to uncritically include new technologies into practice, a de-emphasis on technology associated with the 'dirty work' of nurses and limited investigation into the historical development of nursing technology (Sandelowski 2000).

KNOWLEDGE AND SKILLS

The second or middle concentric circle in Fig. 13.1 portrays technology as knowledge and skills. Artifacts and resources have professional meaning(s) that are in many ways determined by the knowledge and skills associated with their use (e.g. advanced technology in the ICU) and their usefulness in terms of reliability and functional design. Knowledge and skills contribute to the successful use of artifacts and resources and are therefore as much technology as the machines and tools we use. Without required knowledge and skills for the use and application of technology, it has limited ability to meet the needs of nursing practice and care. For example, without the skills necessary to

use a computer, it is not much more than plastic, metal and electricity, and will not assist daily practice. Without knowledge to interpret or efficiently fix a problem associated with technology (such as an alarm on an infusion pump), the technology is of little use and may well be a dangerous addition to patient care.

Nursing is a practical profession and our knowledge is expressed most often through the way we perform our work. To this end, we focus often on what we do as practitioners and explain technology from perspectives that emphasise daily roles and responsibilities. For example, there has been debate concerning the increasing role of nurses in the use and maintenance of machinery and equipment. It has been argued that nurses have to fulfil the role of technician, and this is significantly distracting us from focusing on the experience of each patient (Boykin & Schoenhofer 2001).

Nurses rely on experience, continuing education, personal development and peer mentors to maintain and develop knowledge and skills that are associated with technology. Failure to establish and develop knowledge and skills is inadequate for practice and unhelpful to patient care, colleagues and the requirements of the healthcare sector. Knowledge takes many forms and relates to not only competencies related to nursing intervention, but also organisational policy, understanding scope of practice, interpreting quality and safety frameworks, and keeping abreast of rapidly evolving research evidence. These all form part of the development of technological competence, which is central to technology–nurse–patient relations and is vitally important for care.

The outcome of technological competence is not only the development of skills for technology use, but also our ability to know 'the other' (i.e. the person whom you nurse) as an individual. Thus, when using technology in care we need to know and understand individual preferences, culture and beliefs. This significant part of caring is achieved as an outcome of purposefully seeking to know the person as an individual and through making appropriate use of technological data and resources for their benefit (Locsin 2001). This aspect of practice is an equally important component of technological competence. Patients trust that nurses will have the competence necessary to professionally use technology and demonstration of competence reduces anxiety and fear and increases the likelihood of successful care outcomes. Advances in organ transplantation, genetics, pharmaceuticals, microsurgery, virtual reality, e-health, telehealth and so on demand an equal ability on our part to update and adapt knowledge and maintain technological competence.

Knowledge and skills alter regularly and thus an active interest in maintaining and advancing competence is a sign of a caring and responsible practitioner. That person will be empowered and able to be accountable for the quality of their practice. Attitudes that reflect an offhand and neglectful interest in updating knowledge and skills are inadequate and reflect a failure to value the importance of people for whom we care. It is a denial of the many possible contrary indicated outcomes that might arise from inadequate technology integration and is unprofessional.

Technology introduces options for care and can make clinical practice more efficient, quicker and more accurate. Skills alter as a result of technology, and this fact should encourage personal reflection on the nature, relevance and impact of change on individual and collective practice (Locsin 2001). For example, an automatic blood

pressure monitor de-emphasises manual skills related to assessing a person's blood pressure, but demands new skills in terms of using the automated machine to obtain useful data. Many skills that were required previously for nursing are no longer necessary for contemporary practice and new skills emerge regularly to become part of daily care. For example, the practice many years ago of boiling urine in a test tube to analyse urine was replaced by the use of a coloured test strip, and the electronic blood pressure monitor and wearable mobile monitors replace the use of a hand-operated sphygmomanometer.

We do things more quickly, more efficiently, with more automation and at times with more accuracy, yet there is inadequate clarity about the relationships between the social nature of nursing work, changing healthcare contexts, theoretical interpretation of nursing and the realities of nursing work (Darbyshire & McKenna 2013). For example, the effect of technological change on nursing skills has been analysed poorly, yet at a practical level, changes are linked to increasing technical complexity, alteration to professional autonomy, digitalisation of healthcare context(s), and a commonplace sense that there is not enough time to do everything (Barnard 2002, Sandelowski 1999b, 2000).

TECHNIQUE

The influence of technology on the organisation of practice is most obviously illustrated in the third and most inclusive concentric circle in Fig. 13.1, which highlights the concept of technique. The third circle extends our character-ology of technology to include the way systems, policy, politics, economics, ethics, organisational management and human behaviour are organised for the benefit of technology. The way nursing practice is organised by technology is as important as the first and second levels of explanation. Technique is not a specific thing. Rather, technique is a way of thinking and organising everything around us. It is an attitude and a social and professional framework that has an enormous influence upon each one of us.

Technique interprets naturally occurring phenomena such as reflective thinking, communication and human relationships in terms of organised and controlled events. An example to illustrate technique might be the difference between a caring moment with a patient motivated by a nurse's compassion for another, versus the preplanned application of communication strategies to construct a relationship based on predefined goals and outcomes. The latter has all the hallmarks of technique because there is emphasis, for example, on efficiently undertaking an activity, yet it can so often lack the humanness of personal commitment and connection. According to Lovekin (1991), technique is the consciousness that gives machines force, which sees everything else as machine-like or as needing to serve the machine-like, the ideal towards which technique strives.

Technique reduces the means of production, whether they be machinery or people (nurses), to that which is most efficient in order to create a unified and predictable activity. Examples of technique in the management of healthcare services are economic rationalism, protocols, risk assessment, action planning, communication strategies, benchmarking, patient dependency models, systems theory, clinical pathways

management and standardised care plans. A transformation is occurring in which many aspects of our practice that were once instinctive, reflexive, natural and particular to individuals and cultures are being transformed into rational method and intervention (Allan et al 2009, Faltholm & Jansson 2008, Sandelowski 2000). In craft-based technology the worker is able to express themselves with a sense of creativity, pride in personal agency and autonomy in determining action and expression. In automated technology environments these values and experiences have a tendency to be replaced by a sense of dependency on predetermined actions, protocols and practice frameworks that permit partial exercise of personal ability and preference and knowledge that personal input can be replaced by another (Ferre 1995).

Technique is a complex phenomenon that is constituted by three subtle yet important characteristics. First, technique adheres to a *primacy of reason* to govern practice. It is a way of thinking, acting and living by which people attempt to control the internal, passionate and emotional world of everyday life via protocols, rules, evidence, frameworks and general observance to a logical order. Second, it requires a *desire for efficiency* in order to assist its goal and to justify its activity. The desire for efficiency is akin to the inventor or factory owner who seeks to streamline methods and actions in order to maximise outcomes. Efficiency seeks practical utility and a guaranteeing of results. There is a striving to reduce waste and the construction of systems that simplify and systematise previously uncontrolled or random activity. It must be stressed that there is nothing wrong or dangerous per se with a desire for reasoned activity or efficiency. In fact, there is nothing new about order or efficiency as reasonable and worthwhile goals. They have both guided invention and activity throughout human history, and, after all, who wants to be exposed to ineffective care?

However, the third characteristic of technique brings about new and different activity because it stresses primacy of efficiency in *every realm of human activity and thinking.* Technique has become so prevalent in society and healthcare that professions such as nursing are increasingly incapable of thinking outside its boundaries in their search for meaning. There is emphasis on control, efficiency, policy and order within a climate of litigation (Neuhaus et al 2002, Sinclair & Gardner 2001).

Technique reduces thinking and human-centred activities such as nursing to measurable and predictable outcomes. Technique brings about qualitative transformation(s) in care since nursing practice risks becoming a robotic-like activity that does not require its practitioners to be particularly caring, compassionate or necessarily understanding of the experiences of people. As a result of technique, a new struggle has emerged for nursing and we need to find ways to authentically respond to individual need(s), cultural difference(s) and personal choice.

REFLECTION

Discuss the implications of technology for the role of the clinical nurse. What will be three important issues to consider for your practice?

Technology, nursing and professional empowerment

Empowerment can be measured at an individual, organisational and community level, and is associated with the ability to make independent decisions and maintain individual autonomy at a personal level (Masi et al 2003). Professional empowerment is associated often with ownership of knowledge, especially knowledge linked to a specialist or professional group. Empowerment is achieved when members of a professional group experience a rise in their status through increased autonomy, skill and competence. This type of achievement reflects what Manojlovich (2007) refers to as the three available areas of empowerment for nursing, being: control over the content of our practice, the context(s) of practice, and competence. It is unfortunate, however, that for nursing, power has arisen less often in association with ownership of knowledge and skills. We have had difficulty confirming the specifics of nursing and nursing knowledge is associated with gendered skills of caring that are valued less by society and healthcare (Barnard 2016, Barnard & Locsin 2007, Henderson 2003, Rinard 1996).

Notwithstanding, in many clinical environments we have accepted new roles and responsibilities that have originated from the introduction of technology and the reassignment of duties from medicine (e.g. diagnostics and assessment). As a result, there is consistent reliance within healthcare sectors on our knowledge and skills and this fact has been interpreted as a demonstration of professional success (Almerud et al 2008, Sandelowski 2000, Santos & Oliveira 2016). Nurses are often the only healthcare workers who possess the necessary knowledge and skills required to operate particular machinery and tools in clinical environments. Technology cultivates for nurses enhanced respect, importance and uniqueness, and when it is used well, these qualities transfer to nursing as a profession (Blandford et al 2014, Dean 2016, Granados-Pembertty & Arias-Valencia 2013).

Future professional advancement for nursing in increasingly multidiscipline and technology-dominated contexts must include even greater inclusion of nurses in decision making for the betterment of patient care (Hutchings et al 2012, Sandelowski 2000, Zomorodi & Foley 2009). McGrath and colleagues (2006) go so far as to argue that the great point of difference between medicine and nursing is our language of advocacy for patient-centred care, rather than medical decision making. Expertise in clinical practice is enhanced through our ability to: assess the suitability of technology for healthcare provision, advance person-focused care, sustain effective healthcare initiatives, advocate for patient choice and reinvigorate cultural, spiritual, moral and social values important to healthcare professions. Thus, it is encouraging to note that the United States Institute of Medicine emphasises the need for patient-centred and performance-based care that is devised around healing relationships and the provision of healthcare founded on needs and values.

Importantly, many of the challenges to achieving person-focused approaches in high-technology contexts reflect individual nursing experience(s), assumptions about the role of technology in clinical practice, and the organisation of healthcare, rather than any essential or fundamental conflict between technology and nursing (Blandford et al 2014, McGrath 2008, Rudge 1999, Sandelowski 1999a). In a critical essay on the semiotics of the nursing–technology relationship, Sandelowski (1999a) highlighted the way(s) that language/depiction/sign within nursing has served to create a presumed problem

between nurses and technology. It was argued that there is growing evidence that the current representation of the relationship between nursing and technology does not support the development of practice informed by critical reflection, nor the development of strategies that best enable clinical decisions to be made about the appropriate use of technology.

To inform our practice we therefore need guidance as to what is important to consider about the relations between technology, nursing and empowerment. The following principles are proposed as a kind of practical and tangible ethic (Borgmann 2006) to inform individual practice and collective discussion, compromises and decisions related to both healthcare intervention(s) and (re)invigoration of social and public service.

TECHNOLOGY AND NURSING IS POLITICAL

The clinical environment(s) of a specialist unit, community facility or a healthcare organisation impact on the usefulness of technology. For example, a hospital unit that is designed poorly in terms of its layout or is resourced inappropriately is unsuitable to accommodate modern machinery and automata. Nurses can spend excess time and effort attending to technology and compensating for the inadequacies of poor resources. When resources do not foster adequately the use of technology, when it is defective or deficient and when support is not provided to foster skills and knowledge, nursing care with technology becomes difficult and less likely to be of quality. Technology under these conditions can become a burden and it is noted that evidence is lacking as to the effectiveness of some technology for patients and healthcare (Parente & McCullough 2009). Funding, ward design, appropriate equipment and resources are crucial. When the practice environment is inadequate, the experience of integrating technology into care can be one of frustration, compromised health and safety for patients and staff, inadequate patient care and decreased efficiency and effectiveness (Blandford et al 2014, McGrath 2008).

A large part of nursing practice is the need to organise busy and demanding clinical environments, which are increasingly complex, are subject to change and dominated by policies and protocols that govern patient care. Patients are often acutely sick and nurses can experience a lack of certainty in their clinical practice (unpredictability, varying demands on time, numerous roles and responsibilities) due to the demands of busy and complex clinical environments. We rely upon appropriate technology to assist us, as shown by the following quotation from a nurse explaining her experience of technology:

> *[T]echnology has so many advantages that if you are without it and you are busy, you do notice the difference. You tend to be more rushed and you don't have as much time to stop and chat … to your patients.*
>
> *(BARNARD 1998:169)*

If the technology works effectively, and is used appropriately, it provides substantial

assistance to establishing safe and predictable patient care. It can assist a nurse to coordinate care successfully, but we need to be involved in determining the usefulness and applicability of specific technology(ies) (McGrath 2008, Sandelowski 1997, 2000, Walters 1995). Decisions regarding access to particular technology and their acquisition and use are always political, yet impact directly on nursing practice and the patients for whom we care. When new equipment arrives, it has to be integrated not only in terms of its financial cost, but also in relation to skills and knowledge change. New technology means new skills to learn, new policy and another potential requirement to undergo further competency assessment. If new technology is essential, make sure everyone is doing everything they can to support its integration into your practice, through initiatives such as in-service and support.

PEOPLE HAVE A RIGHT TO QUALITY CARE

Appropriate healthcare provided by appropriately qualified nurses is the right of each person. Even though access to technology is sometimes restricted as a result of factors such as physical location, the dignity and worth of all life supports the view that we are responsible to effectively utilise and integrate appropriate technology and to do it to the best of our ability.

However, in increasingly technology-orientated contexts, our ability to provide quality care can be challenged, not often by a lack of compassion or desire to do the best for our patients, but by the pressures of unpredictability. These contexts also tend to be busy and increasingly standardised and controlled through policy, which often does not encourage individual difference(s). Kirpal (2004) and Galvin (2010) identified there is consistent tension for nurses during clinical practice between the need to maintain cost efficiency, provide quality care and being able to complete core nursing practice associated with daily living. Kirpal (2004) argued that the experience is due often to increasing technology-related administrative responsibilities and work not always related to direct patient care. In order to focus on the needs of patients, more strategies are needed to address individual requirements of patients, rather than the needs of technology (Barnard 2016, Barnard & Sandelowski 2001, Boykin & Schoenhofer 2001, Faltholm & Jansson 2008, Gordon 2006, Ihde 2002, Marck 2000, Reiser 2009).

Nurses have a broad range of responsibilities in what are rapidly changing and digitalised environments of care, and as a result the practice of nursing can be exhausting. Simply being asked to 'do a better job' in the midst of so much demand can easily be assessed as unreasonable and unrealistic, but meeting the needs of people in these contexts remains our central challenge. Commitment to practice using holistic and person-centred frameworks remains the goal of nursing, but if you can't achieve it sometimes, does that mean you are less skilled than any other nurse?

Drawing on Ellul's (1980) emphasis on seeking opportunity to live moments of anarchy in technological environments (or perhaps in our case, living moments of radical advocacy), it is clearly the case that we need to be encouraged to make better and more appropriate decisions. Radical advocacy will mean, for example, that a nurse is empowered to advocate for clinical interventions that reflect a patient's individual choice, sometimes even when decisions may be in direct conflict with others (Barnard

2016).

The emergence of the doula in healthcare is an example of an interesting public strategy to try to gain greater influence over individual care choices during birthing. A doula is an advocate employed by a pregnant woman whose role is to educate, but perhaps even more importantly to provide emotional support and advocacy for the woman's choice(s), before, during and after birthing. A central part of the role is to advocate for healthcare that aligns with the woman's personal choice(s), birth plan and expectations. The doula accompanies her during the birthing process and speaks/lobbies on her behalf for care that aligns with the woman's preferred choices and level(s) of intervention (Klaus & Kennell 1997, Koumouitzes-Douvia & Carr 2006). Meta-analysis demonstrates that when a doula is included as an advocate for birthing choice, there is reduction in the duration of labour, less frequent use of medications for pain relief, reduced operative vaginal deliveries and a significant reduction in caesarian deliveries (Klaus & Kennell 1997). Doulas position themselves outside the healthcare system (e.g. not employed by the hospital) and their advocacy for each woman's choice(s) can be in direct conflict with medical staff. Their advocacy for women, however, does lead to a reduction in technology intervention and has significant impact on maintenance of healthcare outcomes at the same time as striving to meet preferences in care (Backes Kozhimannil et al 2013).

Each person has a right to quality healthcare. The dignity and worth of each life supports the view that we must responsibly and effectively integrate technology into nursing practice. Allan and colleagues (2009) note that within a range of demanding healthcare environments, such as caring for people accessing assisted reproductive technologies, the management of patients at distance, for example through remote link, requires a lot of careful consideration and planning to retain human contact and successfully address feelings and emotional distress. Almerud and colleagues (2008) noted one of the greatest challenges for each nurse is to accept the benefits of objective and measurable assistance that is provided through the use of technology, but at the same time positively contribute to the patients' lived experience. That is, we need to encourage and accept assistance provided from technology but maintain the professional goal of preserving the human side of practice (Barnard 2016).

When technology works effectively and is appropriately resourced it will assist you to coordinate and successfully complete nursing care. But as nurses we need to do more than just use technology. During a patient's care we need to regularly ask ourselves the questions 'Is this technology solving this person's problem?' and 'Does this technology really serve to meet this patient's needs?'

TECHNOLOGY IS NOT NEUTRAL AND ALWAYS INFLUENCES NURSING PRACTICE

Technology assists to achieve care outcomes that are complex and significant. However, technology is *not* neutral to care and can sometimes override consideration of cultural, spiritual, emotional, physical and psychological needs as it strives to bring about efficient outcomes (Almerud et al 2008, Barnard 1997, Faltholm & Jansson 2008, McGrath 2008, Sandelowski 2000). Technology always has a seen and unseen impact

upon care, goals and outcomes. It does *not* lead always to treatment outcomes acceptable for patients, but it is *not* an influence that leads always to uncaring nurses in inhospitable wards. Technology will assist you to reach care outcomes across a range of possibilities from positive to negative, and therefore expertise in practice needs to be based upon a holistic framework that informs your awareness and planning. Holism emphasises the centrality of the person and by extension their values, choices and individual desires that need to be acknowledged in their care and management. The emphasis within healthcare upon, for example, standardisation, protocols and integrated systems to manage healthcare delivery, while often extremely beneficial, has to be balanced against a willingness to advocate for the values and expectations of the person for whom we profess to care (Barnard 2016, Galvin 2010).

Technology to a greater or lesser extent alters our capacity to determine and accomplish individual goals, professional approaches to care and principles of nursing practice. It has an effect on what Walters (1994) described as our ability to *focus* attention and effort on each patient and our ability to *balance* technology with qualities associated with caring, such as compassion and connectedness. Technology will often have both a positive and constraining influence on each nurse, especially their ability to find enough time to be involved in personal care and build a nurse–patient relationship. For example, in a clinical environment, technology that malfunctions often, will not save time nor release a nurse to concentrate on practice principles that place the person at the point of primary concern. These conditions will not necessarily deliver the treatment your patient wants, can cause distress and uncertainty and will restrict the daily delivery of care. Poorly integrated technology will make the daily practice of nursing more demanding, time consuming and distracted. Practice environments may be dominated by excessive policy and governed by protocols that constrain care. They may be noteworthy for their need for you to constantly check equipment that alarms repeatedly and for a need to be involved administering a lot of medication. It is not unusual for technology to become a compelling and sometimes draining influence upon a nurse's time, physical commitment and intellectual attention.

Keeping a focus on person as the centre of practice is extremely difficult in technologically demanding environments. It can often be a challenge to balance the importance of human, technological and organisational requirements, especially when the demands of telephones, buzzers and checking equipment can draw us away from the other things we need to do (Barnard 2000, Galvin 2010, McGrath 2008). The following nurse explained her experience noting that:

> *All those alarms and monitors, they're geared to catch your attention aren't they? I mean, that's why they have alarms. So the first thing you do when you have alarms is go to it. It's like telephones at home. The first thing that you do when the telephone rings, it doesn't matter how busy you are, you drop everything and answer the phone, instead of saying, it's just a phone, leave it ring. I mean you put telephone answering machines on telephones these days, because the phone has to be answered doesn't it? We're geared these days to attend to noises and equipment before we attend to people.*

(BARNARD 1998:193)

Galvin (2010) notes that clinical practice in these types of contexts is about balancing the hand (technical skills), the head (the requirements of protocols, evidence and legislation) and the heart (ethical and human-centred concerns). You cannot use technology without also, to some extent, being influenced by its use, because in clinical practice machinery and devices become a second patient also requiring our care, touch and assistance (Monteiro 2016). Our ability to show we care can be challenged, not commonly by our lack of compassion or understanding, nor a lack of desire to be involved more with people, but by the technology we use. It is important to acknowledge that technology in our practice will and does influence nursing practice and the care we provide to patients. Most nurses want to participate in patient-focused care based on genuine compassion and concern. However, sometimes technology and the way(s) we use it gets in the way of our ability to express the desire (Barnard 2016, Galvin 2010).

GOOD HEALTHCARE MATTERS BECAUSE PEOPLE MATTER

Three effects of technological progress were identified by Schön (1967) who described them as desired, foreseen and unforeseen effects. It has been observed that the effects to arise from technology on any one individual or group cannot be predicted fully and this reality is a primary feature of technological progress (Ellul 1990). It is therefore reasonable to assume, based on what we know, that adequate use of technology requires all healthcare workers to assess the likely effects of technology on patients. Our goal must be to try to reduce unexpected effects and adapt care to the likelihood of unreasonable outcomes.

Negative consequences of technology such as objectification and loss of human dignity are documented in the literature (Bull & Fitzgerald 2006, Sandelowski 2000). Yet very often with foresight and courage it is possible for nurses to emphasise choices in care and the uniqueness of each individual patient. Even during intervention, such as emergency resuscitation of a child, clinical intervention can include family and an emphasis on the dignity of the person (Barnard & Sandelowski 2001). Turkel (2001) explained her experience of a nurse who advocated for compassion to allow family members to be with a patient (family member) during resuscitation. The nurse almost lost her job, but it was noted that the hospital later changed its policy to allow the practice (Barnard 2016, Turkel 2001). This type of radical advocacy translates to a willingness to identify practice(s) that benefit patients and family, and highlights a readiness to participate in action(s) that encourages healthcare that is more than just the status quo (Barnard 2016, Zomorodi & Foley 2009).

Expression of professional empowerment is exercised in the best interests of individual patients and significant others. It has a degree of associated risk, but may lead to care practices and expressions of caring that are directly related to what people want in their care (Lindahl & Sandman 1998). Good healthcare matters because people matter and radical nursing in defence of this moral value can be expressed at a number of levels (Barnard 2016). Nurses who follow caring frameworks are noted to look for

opportunity to express their values and aspirations to make caring the central focus of their nursing practice (Boykin & Schoenhofer 2001, Schoenhofer 2001). Expression of caring goals can occur when in direct contact with patients, but also may occur when purposefully writing more in-depth and holistic patient reports, expressing nursing in artistic forms such as poetry, or taking the opportunity to talk with colleagues about caring. While these and other activities may not be for every nurse, these examples express the concern many nurses have for taking the opportunity, wherever possible, to promote caring by emphasising a commitment to advance an agenda that communicates ways of expressing the values and practice of nursing in technological environments through direct and indirect patient care (Allan et al 2009, Barnard 2016).

CONCLUSION

When technology is used well in clinical practice it improves the effectiveness and efficiency of nursing, empowers carers and establishes predictable measures and assessment. It assists greatly in our ability to understand the physical condition of the patient, and saves time by making patient assessment increasingly accurate and potentially reliable. These advantages are extended further when we properly integrate technology into our practice as expertise and competence. Importantly, technology–nurse relations are more than just being able to use and manage equipment.

REFLECTION

Highlight three initiatives you can lead in your clinical context to encourage an emphasis on patient-focused care.

Gordon (2006) demonstrated that in literature and practice, there is an ongoing separation between the technical aspects of care delivery, and the day-to-day subjective experiences of patients. We tend to highlight the hands-on aspects of care, without an equal emphasis on both explaining the experiences of patients, and the personal nature of healthcare delivery.

There is nothing minor or insignificant about technology and it will continue to have a major role as a change agent in healthcare (Barnard 2002, DeVries & Barroso 1997, Sandelowski 2000). Future research is needed to identify strategies that better empower and enable nurses to integrate technology into practice. The answers to the challenges we face probably lie in political action, individual advocacy and a willingness to plan and enact care based on individual patient needs. Collectively, however, we need to grow a willingness to maintain a certain detachment from the excitement of new technology(ies), and the demands that technique tries constantly to impose on healthcare through governance of our practice. We should not underestimate the challenges before us. Occupy yourself with understanding the needs of people and weighing those against the advantages and difficulties of technology. In undertaking this duty, we empower ourselves as significant contributors to healthcare.

REFLECTIVE QUESTIONS

1. What five important things does this chapter tell you about the relationships between nursing, technology and professional empowerment?
2. Select a piece of innovative technology in nursing. Imagine that this was new to market and not yet readily available in your hospital. What strategies and approach may you adopt to advocate the hospital purchase or trial this new technology (e.g. patient-controlled analgesia pumps are now widespread in surgical nursing. This was not always the case)? How would you have advocated for their purchase and use?

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CHAPTER 14: NURSING PRACTICE AND DIGITAL HEALTH INTERVENTIONS: A FOCUS ON IMPROVING CARE

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KEY WORDS

adaptive change; clinical; information; digital health; interventions; electronic; medical records; improving care; safety concerns; workarounds

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- consider the design, development and implementation of digital health interventions using co-design principles and approaches;
- understand barriers and opportunities for the use of digital health interventions to improve patient outcomes and care;
- understand how digital health innovations underpin intelligence-informed healthcare;
- appreciate the role of technology in supporting the use of data to improve patient safety and clinical quality;
- discuss the innovative technologies available to nurses that can improve patient safety and clinical quality.

INTRODUCTION

Recent research suggests that nurses perceive that they are currently inadequately prepared for the digital age, not ready to lead decision making about the adoption of digital technology, facilitate digital literacy or model digital professionalism in healthcare (Mather et al 2019:1). Given the rapid spread of digital health interventions across healthcare and nurses' pivotal role in leading and delivering healthcare, it is essential to address this gap.

This chapter provides a high-level overview of the intersection between digital health interventions and nursing practice. Digital health is a rapidly growing field with an ever-expanding body of knowledge and evidence supporting its adoption. It would not be feasible to cover all aspects in a single chapter. This chapter establishes a baseline of understanding that can both inform current nursing practice and form the basis of further study or exploration. The chapter provides the reader with a practical definition of digital health technology that can assist with promoting meaningful use, an overview of the current state of play in the UK, the USA and Australia, and an introduction to the opportunities and challenges that are associated with the digitalisation of healthcare. We have focused on the implementation and impact of digital clinical records, as both nationally and internationally these form the backbone of digital health strategies. Importantly, the chapter should assist nurses to become aware of the frontline clinical practice implications that are associated with digital health interventions.

Data driven care

There is no doubt that the introduction of digital technology in health has brought, and will continue to bring, significant change in the way that care is delivered. The widespread adoption of digital technology has already highlighted many potential benefits to healthcare (Bates & Gawande 2003, Hughes 2008, Tinschert et al 2017). The goal of digitalisation in healthcare has been widely accepted as promoting healthcare's quadruple aim: better health; better healthcare; lower cost; and increased professional satisfaction (Bodenheimer & Sinsky 2014). There is reasonably strong evidence, for example, that if implemented and used appropriately, digital clinical information systems support safer, higher-quality care than that delivered through the use of paper-based information systems (Berwick et al 2008, Sheikh et al 2015). Alongside the evidence for improvement in the safety and quality of care, there is also an increasingly compelling body of evidence that points to unexpected disruption in the delivery of care and threats to patient safety when digital health interventions are introduced into healthcare systems (Kim et al 2017). Understanding the tension between intended and unintended consequences of the introduction of digital health technologies into healthcare environments is critical to achieve the balanced objectives of the vision of the quadruple aim.

Delivery of healthcare is driven by data—how it is collected, shared, understood and used. At all points in the patient care journey, data collected about patients, their

medical conditions, their families, significant others and their socio-demographic context, influences strategies to engage them as partners in care; clinical decision making; clinical handover; and care coordination. Intelligence-based practice in healthcare requires access to accurate, complete and timely data that is used to make informed decisions about an individual patient to ensure care is effective, safe and appropriate. In the same way, data gathered from the care of many patients drives research, innovation and the development of outcomes-based clinical protocol improvements.

The need to access and share clinical information supports most healthcare interactions. For example, medical, nursing and allied health clinicians require access to accurate information about patient medications, treatment plans and condition; acute care teams need timely, accurate information about changes in a patient's condition that might signal clinical deterioration; patients need clear information to support self-management of their health; and post-discharge care requirements have to be shared between primary and acute care providers to ensure effective clinical handover and continuity of care. However, as healthcare delivery becomes more complex, the ability to collect, access and interpret all the available information using paper-based systems has become almost impossible. This means that critical information necessary to deliver safe, high-quality care can be delayed, misinterpreted or lost. The application of digital technology to clinical care has become a necessity in an information-dense environment. Indeed, as the volume of information grows, there are increasing concerns that clinicians will be unable to function optimally in the future without technological assistance (Taylor & Properzi 2019).

Nurses play a pivotal role at all points in a person's lifetime health journey. As clinicians that support patients' needs from birth to death, nurses work with individuals, communities and other health professionals to deliver optimal health outcomes and safe, quality care. At each of the myriad touchpoints there are opportunities at the micro, meso and macro levels to use digital health technologies to improve health and healthcare systems. Nurses are optimally placed to take up leadership roles that support the introduction of digital health technologies at both population health and clinical levels. Already in their everyday practice, nurses are involved in the collection, aggregation and analysis of data. They work alongside patients living with chronic disease and disability; they provide care within the aged and social care systems; and are the backbone of the acute care system.

In hospitals, nurses navigate digital records to undertake online charting, reviewing charts and recording observations; to update health records and to schedule care or arrange referrals and appointments. As part of their day-to-day work nurses use electronic diagnostic equipment (e.g. digital thermometers, blood pressure monitors, cardiac monitors and pulse oximetry), and increasingly are incorporating mApps and clinical decision support tools into their practice.

One of the persistent challenges in the implementation of digital technologies in health has been aligning the technology to the existing, routine processes of care. Compared with other industries that have adopted digital technology (e.g. manufacturing or banking), healthcare has been relatively slow to integrate digitised

technologies. It has been suggested that this could be related to the nature of the work itself (Granja et al 2018). While workflow is mainly linear or straightforward in high adoption industries, in healthcare the typical workflow is adaptive, complex and nonlinear (Granja et al 2018). On any day clinicians make decisions and deliver care based on myriad factors that are highly contextualised to specific environments and patients. Integrating technology into healthcare requires understanding work *as it is done,* rather than work *as it is imagined to be done* (Granja et al 2018, Hollnagel et al 2006). What this means is that introducing digital health interventions successfully requires more than implementation of a technology. Simply digitising the current workflow or system of care will not realise the full quadruple aim benefits that technology can offer. What is required is adaption of the current workflow to derive optimal benefit—a change in the way work is actually done. Involvement of nurses and other clinicians in the processes of human-centred co-design, implementation and evaluation is necessary to achieve the socio-technical change required for optimal adoption (Granja et al 2018).

Implementation of digital technologies is only the first step. Technologies currently in use will continue to evolve as adjustment to the clinical/technology interface improves. As primary users of digital health interventions, nurses will have a key role in supporting their ongoing evolution and adoption. All nurses will need to be skilled in using technology as an effective tool to improve patient care and outcomes. They will also need to be able to competently evaluate the impact of technology as it is introduced into clinical care. In the same way as nurses participate in quality improvement for any clinical practice innovation, they will need to be knowledgeable in how technology works and how it can lead to improvement, or risks, in care. Some nurses will become champions and lead adoption and innovation in the use of digital technology in their practice area. And a smaller number will choose clinical informatics career paths and help shape the design and future of digital health technology.

What is a digital health intervention?

Digital health technology is a broad term that is used to describe any number of innovative technologies applied to health or healthcare. The term can include categories such as mobile health (mHealth), health information technology (HIT), wearable devices, telehealth and telemedicine and personalised medicine (Vayena et al 2018). In 2018, the World Health Organization (WHO) published the Classification of Digital Health Interventions v1.0 (WHO 2018). The intention of this classification system was to provide a shared language for technologists, clinicians, implementers, vendors, researchers and governments to describe the uses of digital technology for health. The WHO argued that even though there were existing frameworks for classifying digital technologies (e.g. Control Objectives for Information and Related Technologies (COBIT) (ISACA 2018), Health Level Seven (HL7) (Health Level Seven International 2007) and International Standards Organisation (ISO) (ISO 2014)), these were, in the main, highly technical classification frameworks that were intended for use by computer scientists and software developers in health. The WHO classification simplifies the language to support better communication between health practitioners and technology-oriented specialists collaboratively engaged in adoption of digital technologies in health.

Importantly, an objective of this improved communication was to ensure that there was a shared understanding of the purpose of the introduction of a technology, its clinically meaningful use. Much of the early introduction of a key digital health technology, clinical information systems for example, was driven by efficiency and economic requirements primarily intended to support billing, coding and reporting functions (Wachter 2016).

The WHO classification organises digital health interventions into four overarching groups based on the targeted primary user: interventions for clients; interventions for healthcare providers; interventions for health systems or resource managers; and interventions for data services. This classification makes visible the primary intention of digitalisation and creates explicit purposes that address health and clinical improvement priorities. Examples of digital health interventions have been mapped in the classification to identified health system challenges to show how technology can address identified health needs and support program planners to articulate what they hope to achieve through digital health technology (WHO 2018).

DIGITAL HEALTH TECHNOLOGIES

There is increasing popularity in the use of mobile communication devices, including wearable fitness trackers and smart devices to deliver health services or information to consumers. In 2015, there were more than 100,000 mApps available (Zelmer et al 2017). These devices, combined with the power of big data analytics, could help develop new care pathways and identify high-risk individuals (Adibi 2015).

In 2016, the four leading categories of new digital health technology investment were: patient experience; wellness; personalised health (genomics) and quantified self (wearables); and medical devices. These technologies present major opportunities to improve consumer engagement, build holistic personalised health profiles, and understand healthcare disease trends in order to improve the development of new products and services.

Examples of digital health technologies introduced into the healthcare environment to support patient- or clinical-related outcomes that are evident in almost every area of clinical practice may include:

- wearable devices that monitor and communicate clinical measures, for example blood pressure or blood glucose monitors (e.g. Hwang et al 2019, Kim et al 2018)

- smart pumps or infusion devices with built-in dose calculation software designed to identify and correct pump-programming errors (e.g. Furniss et al 2019, Ohashi et al 2014)

- automated medication-dispensing cabinets designed to dispense medication at the point of use in a controlled manner and to track healthcare providers accessing the system, track medications dispensed to patients, and

track medications not administered in accordance with an order (e.g. Berdot et al 2019, Burton 2019)

- digital clinical/medical records which allow healthcare providers to directly enter information about care delivered into patient charts via a computer and access these records remotely to improve decision making and care (e.g. Allen-Graham et al 2018, Hydari et al 2018)

- Clinical Decision Support Systems (CDSS) designed to improve clinical decision making, increase coordination between care providers and promote the use of evidence- or consensus-based guidelines (e.g. Downing et al 2019, Zafar et al 2019)

- mobile applications used by patients to monitor and self-manage their own health—these can include wearable sensors, and apps that allow patients to directly share information with their care providers, for example asthma or diabetes management apps (e.g. Davis et al 2019, Tan et al 2019)

- Clinical Prescriber Order Entry (CPOE) systems that allow direct entry of medical orders by a medical practitioner or nurse practitioner, reducing errors associated with hand-written orders or referrals (e.g. Holmgren et al 2019, Wimmer et al 2019)

- social media, including Facebook, Twitter, YouTube and Wikis, are used as marketing and communication tools to educate patients, and promote wellness behaviours (e.g. Chan & Chen 2019); disseminate clinical recommendations to clinical staff (e.g. Ng et al 2020); support communication between patients, clinicians and communities of practice (e.g. Shah & Topf 2019, Subbiah et al 2019); and access patient perspectives and insights (e.g. Cook et al 2019). (See Table 14.1 for examples of health-related social networks.)

TABLE 14.1

Health-related social networks

SOCIAL NETWORK	FOCUS
MedHelp	Online health community that partners with hospital doctors and medical research institutions to deliver online discussion boards on healthcare topics
CureTogether	Crowdsourcing initiative that brings patients and researchers together to find cures for chronic conditions

Vitals	Online search tool to help consumers search for the best medical care
DailyStrength	Online social network centred on support groups, where users provide one another with emotional support by discussing their struggles and successes with each other
PatientsLikeMe	Online patient network that connects patients with one another, whereby they can share their experience with disease, share their health data to track their progress, help others and contribute to research that advances medicine, improving their outcomes and enabling research
Inspire	Online health community providing a safe and secure place for patients and caregivers to support and connect with one another
FacetoFace Health	Online health community that connects one-on-one with others who share similar health experiences

Bichel-Findlay et al 2017.

Lessons from global implementation of digital health technologies

GLOBAL STRATEGIES FOR DIGITAL HEALTH TECHNOLOGY ADOPTION

Governments and health systems worldwide are increasingly adopting or planning to adopt digital health technologies (Wachter 2016). More than half of World Health Organization (WHO) member states now have an eHealth strategy and it is becoming mainstream for countries to have policies for managing digital information (WHO 2017). The WHO Global Observatory for eHealth reported in 2016, based on its survey of member countries, that 47% of the member countries had a national electronic health record and that 83% reported having at least one mHealth initiative in place. The use of Telehealth is continuing to grow, with 77% of member countries reportedly utilising tele-radiology and tele-pathology, and remote patient monitoring in use in almost half of member countries (WHO 2017).

The WHO global survey further reported that 78% of the member countries had legislation in place protecting personal information, and more than half (54%) have legislation to protect the privacy of electronically held patient data. Nearly 80% of the member countries reported the use of social media for the promotion of health messages. However, only 17% of the member countries reported having a national policy or strategy regulating the use of 'big data' in the health sector (WHO 2017).

ELECTRONIC HEALTH OR MEDICAL RECORDS

While often referred to interchangeably, electronic health records (eHRs) and electronic medical records (eMRs) are in fact different, although related. You could say that the difference is the scope of the information they each manage. An eHR is intended to capture information *across* organisations while an eMR manages information *within* a single care setting, organisation or health system. eMRs may be seen to be a subset of an eHR, or they may operate independently. Australia has adopted a national approach to the introduction of an eHR—MyHealthRecord (Australian Digital Health Agency 2017).

The adoption of an eMR is more likely to be undertaken at an organisational level and there are many proprietary eMR products in the Australian market. One of the significant ongoing challenges faced by health systems in the UK, the US and Australia is the ability to share and use information from different electronic records (Australian Digital Health Agency 2017, Taylor & Properzi 2019, Wachter 2016).

Comparisons of the implementation of electronic health or medical record systems across countries is difficult due to differences in health system structure, policy, funding and culture (Adler-Milstein et al 2013, Zelmer et al 2017). Despite these challenges, and the wide variations in approach to digitalisation in health, a study of electronic record adoption in 38 countries concluded that most countries were aiming to use information technology to increase access, quality and/or efficiency of care (Zelmer et al 2017). To illustrate we provide examples of approaches to implementation of digital health technology in the United Kingdom, the United States of America and Australia.

Electronic health records in the United Kingdom

In the United Kingdom, the National Programme for Information Technology (NPfIT) was launched in 2002 to move England's secondary care sector to a single, centrally mandated electronic care record. It proved far more difficult than anticipated. After much debate the National Health Service (NHS) suspended their digitisation efforts in 2011 after spending approximately £12 billion. Widespread clinician dissatisfaction was in part responsible for the decision to suspend (Wachter 2016). Digitalisation was recommenced in 2016 with a further investment of £4.2 billion. In the United Kingdom, nearly 100% of the GP sector is digitised having begun digitalisation in the 1980s; however, digitalisation of the hospital systems remains patchy (Wachter 2016).

In September 2016 a review was undertaken of the United Kingdom NHS digital health strategy following widespread concerns about the centrally implemented electronic care record. The review, undertaken by Robert Wachter and his colleagues, found that there were 10 overall principles that should inform digital strategy. These were:

1. Digitalisation occurs for the right reasons.

2. It is better to get it right than do it quickly.

3. Return on investment is not just financial.

4. An appropriate balance between centralisation and decentralisation should be sought.

5. The ability for electronic record interoperability and data sharing should be enforced.

6. Data sharing should not be hindered by privacy concerns.

7. Design should be user-centred.

8. Go-live is just the beginning of the process of adoption—not the end.

9. A successful digital strategy requires workforce development.

10. Both technical and adaptive change are needed (Wachter 2016).

There were multiple learnings from the Wachter review that can be used by any health system seeking to launch a national digital strategy. Key amongst these learnings are the balanced use of strategic incentive programs, limited centralisation with an emphasis on local and regional control, an empowered and highly engaged workforce, and the willingness and flexibility to learn from past and from real-time experience (Wachter 2016).

Electronic health and medical records in the United States

In contrast to the NHS's centralised approach, the widespread adoption of digital records in the US was achieved primarily using financial incentives. Adoption of eMRs was accelerated by the allocation of $30 billion to a new program, Health Information Technology for Economic and Clinical Health (HITECH). This program, which commenced distributing funds in 2010, subsidised the purchase of computer systems by hospitals and doctors (Wachter 2016). The HITECH program was supported by 'meaningful use' standards intended to ensure that the computer and digital systems were certified and appropriately implemented (Thornton 2010). At the time of HITECH's commencement, only about 10% of doctors' offices and hospitals had eMRs. In 2015 that number was estimated to be over 75% in doctors' offices and 90% in hospitals (Adler-Milstein et al 2015). Following the signal sent by the introduction of HITECH funding and meaningful use standards, there was a rapid growth in the development of digital health technologies. Adoption of eHRs has, however, consolidated around a small number of commercial systems (Wachter 2016). The meaningful use standards did not focus on issues like interoperability and usability and even today it remains difficult in the US to share electronic information between hospitals and clinics using different electronic systems (Wachter 2016). In 2017, 99% of all large acute hospitals in the US had certified eHRs and an only slightly lower number (93%) of rural or small hospitals had fully implemented certified systems (Office of the National Coordinator for Health Information Technology 2018).

Digital health interventions in Australia

The Australian Digital Health Agency (the Agency) was established by the governments of Australia with a remit to evolve digital health capability through innovation, collaboration and leadership. Its goal was to facilitate digital health integration in the health system (Australian Digital Health Agency 2017).

According to a survey undertaken as part of the consultation to develop the National Digital Health Strategy (Australian Digital Health Agency 2017), the three most

common current digital activities used by those who provided a response were: accessing online clinical reference tools (74%); entering patient notes after a consultation (62%); and patient booking and scheduling (61%). Only 28% of respondents were currently able to share health records with patients, although a further 65% were interested in doing so (Australian Digital Health Agency 2018b).

The Agency developed the National Digital Health Strategy through extensive consultation with the Australian community and comprehensive analysis of the evidence. Australia's National Digital Health Strategy has established a number of driving principles:

1. Putting users at the centre

2. Ensuring privacy and security

3. Fostering agile collaboration

4. Driving a culture of safety and quality

5. Improving equity of access leveraging assets and capabilities

6. Judicious use of taxpayers' money (Australian Digital Health Agency 2017).

Based on the consultation and driving principles, the National Digital Health Strategy proposed seven strategic priority outcomes to be achieved by 2022. These are:

1. Ensuring health information is available whenever and wherever it is needed through adoption of MyHealthRecord

2. Providing secure sharing of information and secure messaging

3. A focus on ensuring interoperability and data quality

4. The provision of better access to prescribing and medications information through MyHealthRecord to improve medicines' safety

5. Support for the co-production of digitally enhanced models of care

6. Support for health professionals to learn how to maximise the benefits of digital tools and services

7. Driving innovation (Australian Digital Health Agency 2018a).

Understanding barriers and opportunities to the implementation of digital health technologies

SUCCESSES AND UNEXPECTED CHALLENGES

Health Information Technology (HIT) has the potential to influence many activities in healthcare delivery—reduce medical errors and duplication of tests, improve communication and access to current and comprehensive patient information, expand the quality of data collection to support decision making, provide transparency around increasing costs, strengthen patient record security and assist healthcare workers in coping with a reduced workforce and increasing demand (e.g. Hosseini et al 2018, Lyons et al 2016, Melton et al 2017, Yontz et al 2015). As noted by Bichel-Findlay and colleagues (2017), improved access to care via virtual clinics and telehealth and improved monitoring using wearable devices or ambient monitoring tools in the home have also demonstrated the benefits of HIT (Banger & Graber 2015). Sharing clinical notes with consumers has been shown to improve medication adherence and engagement (Gerard et al 2017, Wright et al 2015) and many wearable activity trackers incorporate behavioural change techniques that have been associated with improved physical activity in older adults (Mercer et al 2016). A major advantage of using technology is that data are entered once, but can be retrieved and used many times, and automation techniques facilitate the sharing of these data and information for quality measurement, quality improvement, regulatory compliance, research and education (Nagle et al 2009). This will also increase the time devoted to patient care and create a lifelong clinical record (Bichel-Findlay et al 2017).

From a clinical nursing perspective, HIT has the potential to augment practice and add to the development of nursing science in numerous ways. The use of mobile technology, such as smartphones, tablets and workstations on wheels (WOWs), has assisted nurses to access information and document clinical observations and patient care at the point of care in both the hospital and the community settings (Brimelow et al 2019, Ng et al 2020). A major benefit of technology for nurses is to improve and reduce the time devoted to documentation. Utilising electronic systems to capture information about the patient requires structure, consistency and completeness in entry of data. Automation facilitates efficiency in activities such as medication administration, decision support system alerts, worklist reminders and prompts, discharge instructions, nursing care plans and clinical pathways and medication information (Hebda & Czar 2012).

Although there is widespread enthusiasm for the introduction of digital health technologies, early implementation of eHRs or eMRs has shown both successes and unexpected challenges. A structured review of the evaluation literature identified several reported barriers to eHR implementation (Gesulga et al 2017). Importantly, the review found that 50% of eHR systems either fail or fail to be properly utilised. The reasons for these failures included resistance to change, inadequate pre-implementation activities, organisational readiness, issues related to availability of technology and funding, and lack of technical and computer skills. The most commonly reported causes of these failures (in 94% of the reviewed studies) were people-related; for example, user

resistance, inadequate education and training, and lack of awareness of benefits.

An evidence brief reporting impacts of digital health technologies concluded that the evidence for benefits of the introduction of eMRs was largely mixed (Eden et al 2017). While eMRs were reportedly more legible and accessible than paper records, completeness and integrity of information were more likely to be compromised (Eden et al 2017). When the introduced technology requires changes to work practices, clinicians use workarounds (Barrett 2018, Ibrahim et al 2019). A workaround is defined as a behaviour that circumvents or temporarily 'fixes' an evident or perceived workflow block (Debono et al 2013).

Mixed results were also noted for the impact of CPOE and ePrescribing (Eden et al 2017). Positive benefits included cost savings, and individual and organisational efficiency. Mixed results were found for the impact of these technologies on communication. Studies have also demonstrated transmission errors, erroneous dosing and duplicate orders (Amato et al 2016), interruptions and workarounds related to the use of CPOE systems (Baysari et al 2018, Eden et al 2017, Patterson 2018). Findings on the impact of ePrescribing on clinical outcomes, cost and time savings are equivocal. Clinical decision support systems (CDSS) were more consistently associated with positive reported impacts for accessibility, clinical judgement, data integrity, guideline adherence, organisational efficiency and patient outcomes.

A survey undertaken by Sittig and Singh (2013) identified several eHR-related safety concerns including:

#1. **Incorrect patient identification**—most notably the presence of duplicate record creation (more than one record for a single patient) or the insertion of incorrect patient information into another patient's clinical record.

2. **Extended (i.e. > 4 hours) eHR unavailability (either planned or unplanned**)—can lead to either temporary or permanent destruction of data or inability to send or receive information critical to delivering safe care.

3. **Failure to heed a computer-generated warning or alert**—there is widespread non-adherence to computer-generated alerts and clinicians report 'alert fatigue'.

4. **System-to-system interface errors**—errors that occur when information fails to be communicated between systems (e.g. pathology and eHR). These can occur due to errors in data translation or mismatched data fields.

5. **Failure to identify, find or use the most recent patient data**—these problems can occur from difficulties navigating, understanding or interacting with the technology; for example, the need to scroll down, or the need to expand display fields.

6. **eHR time measurement translational challenges**—these risks can occur, for example, when systems use automatic date/time stamps or when routine tests are ordered 'daily' without an end date entered—this can lead to their continuation long after clinically indicated.

7. **Incorrect item selection from a drop-down list of items**—these errors occur when an eHR user inadvertently selects a listed item directly adjacent to the intended item.

8. **Open or incomplete orders**—these can result from a failure to complete the order entry process including signing and submitting.

This early work identifying unintended patient safety risks highlighted the challenges inherent in the process of integrating digital technology into the 'interactive and contingent' nature of healthcare work. Subsequent studies have added to a more nuanced understanding of these challenges (e.g. Horng et al 2019, Martin et al 2019, Melton et al 2019, Wisner et al 2019).

SOCIO-TECHNICAL MODELS FOR UNDERSTANDING THE INTERSECTION BETWEEN TECHNOLOGY AND NURSING PRACTICE

One of the most valuable insights gained from evaluation of past implementations of digital health technology has been the awareness of the importance of the intersection between the use of technology and the process of care. A seminal study by Ash and colleagues (2004) noted two main categories of errors that became evident after the implementation of clinical information systems in the USA, the Netherlands and Australia. These include: 1) errors in the process of entering and retrieving information; and 2) errors in the communication and coordination process. Ash and colleagues identified human–computer interfaces that were not suitable for the complexity of the care-delivery environment and a mismatch between the usefulness of the information entry or retrieval process to the primary task of patient care. The structured nature of data in most clinical information systems can increase the time taken to document or access information leading to significant clinician frustration and can interrupt clinicians' cognitive decision-making processes (Ash et al 2004).

Similarly, communication and coordination errors observed by Ash and colleagues occurred because of the mismatch between the imagined linear process of care and the real experience of a highly flexible, fluid, contingency-based process of care (Ash et al 2004). In this category the main types of errors occurred when systems were inflexible, when they were unable to respond to clinical urgency and in the practice of clinicians developing workarounds to avoid unrealistic or harmful demands of the clinical information system. Ash and colleagues also highlight the problems that might occur when entry of data into a computer system replaces rather than supports previous means of communicating. This misrepresentation of information transfer as communication, potentially results in less effective communication, loss of feedback and

ultimately potential patient harm (Eden et al 2017).

Workarounds and adaptations

Merely installing computers and digital technologies without altering the work and the workforce does not enable achievement of the quadruple aims of digitalisation, and indeed can sometimes get in the way of providing safer, better care (Wachter 2016). Workarounds develop in response to perceived or real intrusions that prevent or undermine nurses' care for their patients (Debono et al 2013). A large ethnographic study, for example, noted that 'black spots' in patients' rooms precluded nurses accessing an active eMR and prevented them from conducting the 5Rs at the bedside when administering medication (Debono 2014). To work around this barrier, nurses left the electronic device outside the room and wrote the patient's name and medical record number on a piece of paper or memorised them. While workarounds have been primarily perceived as negatively impacting patient care, they can also be perceived as behaviours more aligned with innovation and improvement (Debono et al 2013). Studies examining nurses' use of workarounds with technology frequently focus on workflow (e.g. Gregory et al 2019). It is also important to note that features of health technology that support nurses' professional image—that is, those that support them to be what they perceive to be a 'good nurse' (patient-centred, team player, efficient, safe)—are well accepted, while characteristics of technology that undermine nurses being good at their jobs potentially lead to workarounds (Debono 2014). The introduction of technology should consider whether and how its implementation impacts nurses doing what they consider to be important to being a good nurse (Debono 2014).

It is important to understand, therefore, that digitalisation requires both technical and adaptive change. Digital health interventions are often misunderstood to be simple technical innovations. In fact, implementation of digital health interventions is most often a complex change process that requires both adoption of new technology and changes to the way work is undertaken.

Achieving better practice and subsequent improvement in clinical and administrative outcomes requires manipulation of the complex interrelationship between technology and organisational or social change. This is referred to as adaptive change and, increasingly, research effort and implementation is focused on understanding effective change methods that improve successful implementation.

Adaptive change

A common cause of implementation failure is the lack of a detailed understanding of the clinical workflow prior to implementation of a digital technology (Granja et al 2018). When there is a misalignment between the technology and the workflow (often referred to as the user-interface), clinicians can experience frustration, disillusionment and disengagement. Making visible and studying clinical and nursing-developed workarounds presents an opportunity, post implementation of digital health interventions, to uncover misalignment. Understanding that workarounds are not always harmful and can identify innovations and improvements, enables these frontline-developed adaptions to re-engineer the interface, changing both technology

and practice, and improving outcomes.

Adaptive change involves long-lasting and substantial engagement of clinicians, including nurses tasked with the responsibility of using the technology and making it work. Engagement should commence with the process of co-design and continue through to post go-live evaluation and optimisation work. Co-design, which originated as a participatory action research approach, uses participatory and user experience design to bring about quality improvements in healthcare organisations. Optimisation is the process of embedding technology into work-as-done. It requires open, non-judgemental and non-punitive reporting and feedback systems that allow nurses and other frontline clinicians and users to report and discuss the experience with a digital health technology. Capturing and using user experience to make adjustments on both sides of the technology/practice interface narrows the gap between work-as-imagined and work-as-done, and ultimately results in the full integration of a technology into practice.

Data have always been used by researchers to understand and propose improvements in care. The challenge has been, and remains, one of translating academic research into practice—a process that can take many years. A learning health system uses digital information at the point of care to drive iterative, ongoing improvement. The concept of a learning health system is predicated on the availability of digitised information available to clinicians at the point of care (Friedman et al 2010). Routinely turning practice into data gives clinicians at the point of care access to meaningful, real-time information about their care. Turning this information into knowledge provides the basis for practice improvement. Cyclical and ongoing as part of the routine process of care, a learning health system engages clinicians in practice improvement as part of their day-to-day care.

As discussed, one of the challenges in mapping digital health technology to the process of day-to-day care is the nonlinear nature of care as it is provided at the point of care. Unlike other industries that have been successful adopters of technology where the process is unitary, linear, standardised and certain, the process of care can be iterative, recursive, customised or uncertain. While much of this variation in care is necessary to ensure that care is person-centred and responsive, there is opportunity to reduce unexplainable and unacceptable variation in care and outcomes. Digitalisation of clinical information presents an opportunity to make key process information available to be used by frontline staff to support intelligence-based practice to engineer more consistent reliable outcomes. The development and complementary implementation of care pathways or protocols are examples of adaptive change within a socio-technical model that can eliminate variations in care.

Understanding the real nature of work in a complex adaptive system like healthcare is challenging, and very often implementation of digital technologies is based on how managers, technicians and those in leadership positions imagine it is done (work-as-imagined). The notion of a theoretical difference between ‘work-as-done’ and ‘work-as-imagined’ was offered by Hollnagel and colleagues (2006). Work-as-done can almost never be perfectly captured as there is constant evolution and fluid, dynamic changes in the delivery of care as clinicians adapt to the actual conditions that impact on care.

Work-as-imagined can be described as what designers, managers, clinician leaders and others believe should happen in an ideal situation. Designing digital interventions based on work-as-imagined creates a critical failure point in implementation. As noted previously, poorly designed or implemented digital health technology in different settings can result in increased clinician frustration, increased workload and workarounds (e.g. Barrett 2018, Bozan & Berger 2018, Browne 2019, Chaturvedi et al 2019, Debono 2014, Patterson 2018).

Ethical and policy challenges in digital health

There are numerous potential ethical and policy challenges when digital health technologies are introduced in clinical practice (e.g. Ohashi et al 2014, Sansurooh & Williams 2014, Wani et al 2019). Broadly these include, but are not limited to: privacy issues, particularly as they relate to data security; use of social media and bring your own devices (BYODs); shifts in accountability and liability (who is accountable; for example, if there is an error in an algorithm on which a clinician will make a decision that results in harm to a patient); the use of artificial intelligence and the requirement to ensure the same standards for evidence used for other interventions; the potential for de-skilling as clinicians become dependent on technology; and the tension between needing to 'trust' the technology and acknowledging the potential for error or bias. While unquestioning trust in digital technology can result in unintended harm to patients and potential risk of medico-legal or professional action against clinicians, the mechanisms by which clinicians can verify information accuracy are not always clear or efficient. The standard methods for protecting the privacy of health data, for example anonymisation, notice and consent, are inadequate in the face of the new challenges presented by digital health (Vayena & Blasimme 2017). Vayena and Blasimme suggest that it is not possible to provide consent for all possible future uses of data, and re-identification is always a possibility in the realm of digital data. Only about a half of WHO countries have specific privacy protections in place for personal health data.

Opportunities: Implications for nursing practice

In this chapter we have argued that introducing digital technology into nursing practice is not simply a technical process. Almost all technology will impact on the way that nurses practise and how they interact with others caring for patients. Digital health technologies impact on how patient information is collected, documented and used to support clinical decision making. Underestimating the importance of the adaptive changes required when technology is introduced into clinical practice has been one of the reported contributing factors in unsuccessful implementations (Ash et al 2004).

There are many things that nurses, clinicians, administrators and technologists can do to facilitate successful and safe implementation of digital health technology. These include:

- Ensure that you use available technology in your workplace appropriately.
- Contribute to the optimisation of the digital health technology by participating in review and ongoing design and improvement work.
- Get involved in the design and development of clinically meaningful digital health innovations.
- Ensure that you and your staff are fully trained in the use of new technologies.
- Ensure that you provide feedback regarding how new technologies are performing in the workplace and how they could be improved.
- Where possible standardise equipment (Emanuel et al 2008).

CONCLUSION

This chapter has presented an introductory, high-level overview of a range of issues associated with the introduction of digital health interventions. This is a rapidly advancing area of innovation that holds great potential to improve our ability to deliver high-quality, safe care. There are great advances being made by healthcare providers, device manufacturers and software designers. Governments, policy and law makers and administrators are improving governance and security of digital health technologies.

Engagement in this work will require that every nurse, indeed every clinician, understands the impact and opportunity of technological innovation in health and is able to participate in the ongoing work of optimisation, and ensure that digital health interventions are delivered in a way that maximises patient safety and minimises the potential for unintended harm or misuse.

STORY

James, a nursing student averaging High Distinctions, embraced the call to adopt gold standard practices when delivering patient care. He was excited that the ward he was assigned to for his first placement, as a newly graduated nurse, used an electronic medication administration system (EMMS). He anticipated this digital health technology would support him to deliver high-quality care.

Three months into this placement, as he prepares to go to work, James reflects on the shifts he has completed since starting on Nightingale medical ward. It was his first ward allocation in the new graduate program. He had felt fortunate to have secured a position in the postgrad program and had been excited to start as a registered nurse. He was, however, rapidly losing his drive to embrace technological innovations for excellent care, and even his passion for nursing.

Each shift James is conscious of the eye rolling, the displeasing looks, the muttering and the obvious judgement and conclusion by the senior nurses that he is too slow. It has been made obvious that his newly graduated peers have been given opportunities that he has not because, based on demonstrated 'time management', he has not yet demonstrated that he warrants additional responsibilities. He knows that he is handing on more tasks to the nurses on the next shift than the others, even though he takes much shorter breaks and stays back to write up the patients' notes. James is also conscious that he takes longer to complete medication rounds than the other nurses, including some of his newly graduated peers. He has noticed that while he is adhering to all the prescribed steps when administering medication using the EMMS, his colleagues do not always do so.

James is acutely aware that he is one of the few nurses on the ward who uses (or tries to use) the technology as it is intended to be used when administering medication. When administering medication James pushes the computer on the dedicated trolley to the bedside so that he is able to conduct the 5Rs when administering medication. Many of his peers have adopted the medication administration practices elected by the more

experienced staff. He concludes that this is a major contribution to his time management.

There are some patient rooms in which there are black spots, so the computers do not work at the bedside. In other rooms, it is really difficult to get the computer into the room because of the equipment already in there. James spends time moving equipment and furniture out so that he has the room to take the computer into these crowded rooms so that he can legitimately check the 5Rs at the bedside when administering medication. He then has to move everything back into the room, which is a very time-consuming process.

Some of the computers have a very short battery life, which means the computer has to be plugged in quickly in each room. James recalls several occasions when, because he was talking to a patient and their visitors, he had not plugged the computer in quickly enough and, because of the short battery life, it had shut down, losing the information he had entered (about which medications he had put in the medication cup). In each instance, he had thrown out those medications and had started the process all over again. Rather than taking the dedicated computer trolley (workstation on wheels (WOW)) to the bedside to check the 5Rs when administering medication, some nurses leave it in the corridor outside the patient's room, sign off the medication before administering it and either memorise the patient's medical record number and name or write it on a piece of paper to complete the 5Rs.

There are some instances that James has observed when, even though they could have used the technology as intended, some nurses did not because they said it took too long and that they wanted to avoid delays for their patients. They prepare the medications for each of their allocated patients in the medication room, write the patient's bed number or name on the medication cup, sign all the medications off in the computer in the medication room and then take the labelled cups to each patient to administer them.

James feels extremely uncomfortable with these workaround practices. There are times, however, when not taking the WOW to the bedside seems to be best for the patient. For example, when the patient is isolated, taking the computer to the bedside constitutes an infection risk. In those scenarios James takes the WOW to the bedside and thoroughly cleans the trolley and wheels each time he administers medication—again taking him much longer than his colleagues who use a workaround.

James is concerned that his performance review will not be positive. Last night he had been allocated six patients, one of whom, Mrs Jones, had shown signs of confusion and agitation on previous night shifts. According to handover, the nurses had used a range of strategies to help Mrs Jones remain settled overnight. James was reminded of the noise-reducing strategies embraced on this ward, including soft closing bins, soft-soled shoes, call bells diverted to pagers and, where possible, using the sink at the nurses' station rather than in the patients' rooms. Mrs Jones had been asleep since the nurses commenced the night shift. Mrs Breen, in the bed opposite Mrs Jones, was due a medication at 02.00. James had pushed the WOW to her bedside so that he could conduct the 5Rs. The noise of the trolley and the lights of the computer woke Mrs Jones who started calling out, waking the other patients in her room and in the room across

the hall. One of the nurses looked pointedly at James and suggested that next time he might consider the impact on patients' sleep of taking the WOW to the bedside in the middle of the night. James felt torn. He knew that not taking the WOW to the bedside made him professionally vulnerable if he had made a medication error.

Reflective questions

1. How does James' situation reflect the gap between work-as-imagined and work-as-done?

2. How might consideration of the complexity of patients' responses to hospitalisation, environment, equipment and expectations (e.g. Key Performance Indicators) prior to implementing technology have mitigated James' dilemma?

REFLECTIVE QUESTIONS

1. What are the most challenging factors associated with the introduction of digital health interventions in your workplace?
2. What might be the critical success factors to ensure safe, successful implementation of a digital health intervention in your workplace?
3. What opportunities exist for nurses to become involved in technology design and testing in your workplace?
4. How might you ensure that there are adequate pathways that allow clinicians and consumers to provide feedback on the implementation of new technologies?

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CHAPTER 15: HEALTHY COMMUNITIES: THE EVOLVING ROLES OF NURSING

Anne McMurray

KEY WORDS

community; health; nursing; health literacy; health promotion; nursing roles; primary; healthcare; social; determinants of

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- explore a range of community nursing roles;
- explain the concepts of primary healthcare and the social determinants of health as foundational principles guiding community nursing actions;
- establish a set of realistic goals for maintaining the health of a given community.

INTRODUCTION

One of the most dynamic aspects of nursing is the way nursing roles continue to evolve. This chapter shines a light on how nurses care for communities and those whose lives are embedded in them. This includes not only the individuals and families who live in a particular community, but those who are connected in multiple ways with the life of a community through social media, affiliations and personal relationships, or through transient experiences such as occur during a period of ill-health. In all settings, and across these relational connections, nurses recognise that health is created and shaped in the social, cultural and physical environments of people's lives, which can enhance or inhibit health and wellbeing. This is commonly known as the social determinants of health (SDH), a foundational concept for promoting health and wellbeing. The SDH guide actions for reducing health disparities among different population groups, which is elaborated on in the chapter to follow.

REFLECTION

The social determinants of health include a person's biological, family and health histories as they have developed across the lifespan, as well as their experiences in the social, cultural and ecological contexts of their lives.

Because community nurses are focused on the dual goals of caring for the community as well as for those connected with it, they must be mindful of the community's strengths and risks as well as the SDH of community members. Some of these are health services, some are physical attributes such as clean air, food and water, adequate housing and safe neighbourhoods. Just as important is the need to be familiar with any threats to the community's social and cultural life, such as discrimination or intolerance, and environmental factors such as climate change and the evolution of new infectious diseases. The overarching goal that spans all community nursing roles is to promote a high level of population health while fostering an 'enabling community', one that contributes to good health. Community nursing is therefore multidimensional and considerate of the relationship between health and 'place'.

The knowledge base for community nursing is broad and dynamic, and includes the need to understand human behaviour and the many ways people's health can change along their life pathways, and with their experiences in the changing contexts of their lives. Besides having current clinical knowledge and skills, adaptability and leadership are particularly important when the nurse practises as a sole worker in the community setting. The setting may be a person's home, workplace, educational, custodial or recreational facility, day-care centre or clinic. Having the confidence to evaluate the impact of these contexts and the humility to recognise what new information is required to meet people's needs is essential. Community nurses must also be familiar with current trends and research findings in order to practise within an evidence-based framework. This knowledge helps them in identifying the risks and opportunities that affect people's access to health and health services. How this knowledge can be used

within their respective scope of practice and practice setting is the focus of this chapter.

What do we mean by community?

Most people consider their community in terms of geography, as defined by a city, town or rural area, the region, country or continent. These geographies shape people's lives in sometimes predictable ways, and often determine the extent to which they have access to health services, adequate resources for living, and care when it is needed. But closer examination of any particular geographical setting reveals numerous variations. Planning care for residents of any community must accommodate the different needs and resources of men and women at different life stages, different cultures and family types. There are also differences among those with health or disabling conditions, and those whose lives are affected by education, employment, financial resources, and access to neighbourhood supports (CSDH 2008). These constitute the SDH, which are acknowledged by the Australian Institute of Health and Welfare as being essential to health and health services (AIHW 2016). Although each person has individual biological and psychological characteristics, we are all social beings, and our social interactions occur in the communities that define our lives. If a given community is unable to provide jobs, education or culturally appropriate, equitable care and support, the challenges of living healthy lives or providing care for community residents are much greater than when these factors are accommodated.

Another important consideration is the idea of reciprocity. Reciprocity is an ecological term meaning that people affect and are affected by the exchanges they have with their environment. When members of a community act and interact in a reciprocal way, each has an effect on the other, with the potential to either sustain or compromise health. Community members are better able to achieve positive health outcomes when their health is understood as part of these reciprocal interactions where they live, work, play, study, worship or shop, with a sense of belonging, in a safe, supportive and sustainable place (Beck et al 2017).

REFLECTION

Reciprocity helps explain how some communities are able to provide jobs that add value to family life. Consider, for example, the link between women's opportunities for education and/or employment and the adequacy of childcare services; or the link between adequate mental health support services and a young person's opportunities for social and emotional growth.

Changing geographical circumstances can create threats and/or opportunities for people whose lives are affected by such physical characteristics as global warming, natural disasters, drought, fires or extreme weather events. Rural life, for example, holds many risks that arise from the natural geography (floods, or a lack of rain); social conditions (few schools, a lack of health services); or economic policies that prevent people from earning sufficient income. Urban life also holds risks and opportunities for health, depending on things such as adequate housing, employment, community safety, income, transportation, schools and access to health services. The political system that

generates social policies affects people in all geographic locations. Social and cultural policies that affect migration, the role of women, or the rights of same-sex partners can also affect families and therefore their communities. Likewise, government policies that affect childcare, disability support, family-friendly workplaces or the age of retirement also have an impact on family life and the health of its members. The implication of this knowledge for nurses is that without understanding both the constraints and supports available to community members, they may provide guidance or advice that is unrealistic for them in the context of what is occurring in their lives.

For many people, the internet has been helpful in providing access to information on health and treatment options. Online information can help people build the knowledge and confidence to make appropriate, informed decisions about their health, which is called health literacy. This information can help those with diabetes and other chronic conditions manage their health at home. However, the amount and diversity of available information can be overwhelming, so many people rely on community nurses to help translate information from the internet. Nurses can help them search for information on such things as medications as a basis for deciding which advice is appropriate for their condition. An important nursing goal is therefore monitoring how people are using information and, in some cases, providing ongoing guidance, either during home visits, or remotely, through websites, emails, telephone, SMS messages or social media. Clearly, these actions require strong communication skills. When community members are encouraged to gain sufficient knowledge to participate in assessing their needs and planning strategies to address these needs there is a greater likelihood of successful outcomes. Seeing community members as partners in planning and communicating with them appropriately are features of community nursing. Without input from community residents, there is always the risk that service planning and therefore effectiveness of care may not achieve its intentions.

REFLECTION

Health literacy is having adequate and appropriate knowledge and information to work in partnership with health professionals in making health and lifestyle choices. Can you think of some ways community nurses could make sure people have access to valid health information?

Community nursing roles

Community nursing practice tends to attract those who are prepared to work beyond the hospital, in various settings and with a wide range of populations. A feature of community nursing is the emphasis on health promotion; working to keep people and communities healthy. Another source of satisfaction with the role is the opportunity to be relatively independent in managing health and wellness for the population. This doesn't mean that there are not employer expectations or practice boundaries, but in many situations, the nurse has to make relatively autonomous decisions about client needs, planning assessments, caregiving strategies and workflow. Many nurses find this type of practice stimulating and embrace the chance to 'think on their feet' to respond appropriately to an individual, family or community need, particularly when they are the sole practitioner. As with other nursing roles, these nurses rely on evidence-based practice to make appropriate judgements for the right people in the right setting at the right time. It is therefore important for the nurse to have access to relevant research and information, especially where there are few opportunities for discussions with other nurses. Most nurses maintain access to this information from their employer, educational institutions or professional networks such as the Australian College of Nursing's Community and Primary Health Care Community of Interest Group (www.acn.edu.au/cphcnw), the Public Health Associations of Australia and/or New Zealand (https://www.phaa.net.au/, https://pha.org.nz/); or the Health Promotion organisations in both countries (https://www.healthpromotion.org.au/,pha.org.nz/). Nurses new to a community role may begin their career feeling isolated by the responsibilities of practising relatively independently, while others enjoy having the freedom to make their own judgements. With experience, most come to rely on their own resourcefulness, developing the confidence to make appropriate decisions and collaborate with other healthcare team members as required by the situation. Experience also teaches community nurses that there is invaluable knowledge to be gained from each encounter and each community that can be useful in the future.

PRIMARY HEALTHCARE IN PRACTICE

Nursing in and with the community is guided by the principles of Primary Healthcare (PHC). These are explained by the Australian Primary Health Care Nurses Association (APNA) as incorporating personal care with health promotion, illness prevention and community development (APNA 2019b). Nursing actions within a PHC framework are intended to promote equitable social circumstances, equal access to health services, continuity of care, and empowerment for community members through their participation in making health decisions. This requires a person-centred care approach, whereby people's preferences, needs and values are considered (Cooper et al 2016, McCormack & McCance 2010). A common thread running through these principles is an attitude of inclusiveness, which means being sensitive to differences and choices, including cultural differences or social preferences for religion or lifestyles. Primary healthcare also includes the notion that no one nurse or health professional can achieve

individual, family or community health goals. Instead, nurses work with other health professionals and those from different sectors, such as education, transportation or community planning agencies, to advocate for healthy structures and supports for living. Another principle is the need to use appropriate technologies; those that are affordable and reasonable for individuals and families to attain their goals.

It is an exciting time to be working with communities, as despite a common commitment to people and their communities, nursing roles are numerous and varied. The Australian Primary Health Care Nurses Association categorises these nursing roles according to settings as follows:

- community settings—community-controlled health services, juvenile and adult correctional facilities, refugee health, community and social service settings
- general practice
- domiciliary settings—home care, residential aged care, custodial/detention settings, boarding houses, homeless outreach
- educational settings—preschool, primary and secondary school, vocational and tertiary education settings
- occupational settings—occupational health and safety and workplace nursing
- informal and unstructured settings—sports settings, community groups (APNA, 2017).

Some community nurses are attached to a designated community, which may be a rural, remote or urban area. Their role, especially in small areas, is often to provide nursing assessment and care for all residents. Another role involves nurses working with homeless communities, often from a hostel as their base, and with visits to various neighbourhoods to provide care and guidance to the population (Parry et al 2015, Shulman et al 2018). Kelly and Luxford (2017) describe the powerful role of community nurses working with vulnerable, homeless people on the streets of Melbourne. They provide care for homeless people with a range of health conditions and injuries, practising from an inner-city health centre. They describe their most important role as engaging with people to safeguard their dignity and help them cope with the lack of safe accommodation, where they could keep medications, food and other belongings safe. Their description of the impact of community nurses in this context is profound, underlining the importance of being guided by PHC principles and understanding the relationship between health and 'place' when there is no place. Like those who work with refugee and migrant services, their interactions and interventions can have a

significant effect on identifying unmet health needs and helping people access health services (Dennis et al 2016, Taylor & Haintz 2018).

Evolving roles for community nurses have seen them engaged in specialist services, working either in the field or in clinics to provide and/or assist with special needs such as breast care, in vitro fertilisation (IVF), dermatology/cosmetics, stomal therapy, palliative care, custodial care, or drug and alcohol services. For example, the McGrath Breast Care nurses receive referrals from practitioners or hospital facilities and provide home visits or telephone follow-up to women and their families affected by breast cancer (McGrath Foundation 2019). IVF nurses typically work in fertility clinics, in a role that is similar to general practice nursing, but distinctive in that they assist specialists or perform scans and some intrauterine inseminations and embryo transfers as well as providing guidance and support to families throughout the IVF journey (Fertility Solutions 2019). A number of other specialist roles are also similar to practice nursing in that they are affiliated with specific practices or practitioners, such as cosmetic surgeons (cosmetic nursing) or other surgical specialists such as gastroenterology clinics (stomal therapy nursing). Other examples of specialist community nurses include drug and alcohol nursing specialists who work with individuals and families affected by drug- and alcohol-related health conditions (DANA 2011), and correctional health nurses, who provide care to those incarcerated in jails, prisons, remand centres and juvenile detention (APNA 2019a).

Most of these clinicians develop new knowledge and techniques in their respective fields, often with the assistance of a mentor or continuing education provided by their employer. There are also a range of graduate certificates offered by universities and the Australian College of Nursing, which help maintain appropriate knowledge to work within their scope of practice and to prepare for any credentialling requirements. Some community specialties require advanced practice preparation as a nurse practitioner, including a higher degree (usually a Master of Nursing) as well as experience in their area of specialty, supported by continuing professional development (Carryer & Adams 2016, Hyde 2017). Like other nurses practising in the community, for advanced practitioners, home visiting is often an important aspect of the role.

HOME VISITING

Home visits are integral to 'domiciliary nursing', where a nurse may be employed by a government health department or a private agency to provide care either in a person's home or a group residence, including residential aged care facilities (RACF). The objective of this type of nursing is to maintain continuity of care for those who have been discharged from hospital following illness or injury, or to prevent hospitalisation or re-hospitalisation for those at risk of exacerbation of illness. Studies have shown positive health outcomes from care in the home (Australian Centre for Health Services Innovation 2017, Olds et al 2014). A systematic review in the United States showed that home visiting initiatives are effective in mitigating some of the SDH by empowering people at risk of health disparities. This body of evidence demonstrates the power of partnership in assisting communities to maintain health and manage existing illnesses (Abbott & Elliott 2016). The home is an ideal setting for family-centred care in that home

visits can provide important insights into family strengths, risks and needs (Kemp et al 2019). Helping families also requires in-depth understanding of developmental needs as a basis for assisting all age groups, including new parents, their infants and/or other children, adolescents, adults and older persons who may need specialised services such as those provided by outreach mental health services, advance care planning/end-of-life planning or palliative care. Home visits combined with case management and telephone follow-up are an important element in promoting integrated or coordinated care across settings, often as part of a transitional model of care (Coffey et al 2017).

Home visiting is also a feature of some general practice or specialist medical clinics where nurses are employed by either the practice or a specialist to assist them with pre- and post-treatment assessments and follow-up. In these roles, nurses work towards providing continuity of care as well as health education for patient and family health literacy and self-management, where appropriate. In most cases the role is negotiated by the nurse and the employing medical practice or specialist. For example, an orthopaedic surgeon may employ a nurse to conduct a pre-operative home visit to prepare the client for surgery, assess their home environment to ensure adequate support for them on returning home post-operatively, and provide any health education and guidance required by the client and family (Robinson 2013). Many breast care nurses also conduct home visits to help care for their patients and share their specialised knowledge to help women and their carers make diagnostic and treatment decisions. Some general practitioners also employ general practice nurses (described below) to conduct home assessments and provide health teaching for chronic conditions that may require ongoing monitoring. All of these activities are empowering for the patient and family in guiding them towards full participation in their health decisions, which is an important element of providing primary healthcare.

Historically, home visiting was mainly concerned with assessments and minor treatments under medical instructions for such things as maternal and childcare, child development concerns, chronic conditions such as wounds, diabetic, respiratory or cardiac indicators, or activities of daily living. However, in the contemporary healthcare context, the role of home visiting nurses has been extended to include a greater emphasis on the diagnostic role and provision of acute care in the home. Many home visiting agencies provide programs such as Hospital in the Home, and offer a range of services from diagnostic tests to treatments that can include intravenous injections, pump infusions and a range of complex treatments. Australian researchers have shown that this model of care is extremely effective in reducing the number of unplanned admissions to hospital (Montalto et al 2010), which is an acknowledgement of the impact of nurses on managing care in the community.

REFLECTION

What are the advantages and disadvantages of conducting a home visit in community nursing practice?

The central focus of a home visit is assessment, encompassing identification of physical, psychological, social and environmental needs and resources. Interventions

require intersectoral collaboration; knowing what resources are available to assist people with different needs, and liaising with a variety of agencies to help people access these resources. Identifying appropriate technologies is also important in this respect, given that the nurse's recommendations for some supports may be too costly for families that cannot afford them. Having a good understanding of what is available to support people's needs is therefore crucial.

Because of the close involvement with family members, home visiting nurses can have unique concerns about nurse–client relationships. In the first instance, entering a home or residential domain of any kind is a privilege rather than a right, and must be carefully planned. Balancing client needs with the demands of the organisation or nursing service is another consideration. Home visiting nurses typically have a daily caseload based on the mix of clients assigned to their care (see Box 15.1). Employers usually set a standard for time management of visits to ensure they are able to cover the type and number of client needs and allow sufficient time for the nurse to travel between visits and establish or maintain the nurse–client relationships. Time management techniques include maintaining adequate planning to respond to the health issue that prompted the visit, and careful documentation of the goals, plans and expected outcomes of the visit and any preliminary plans for care.

BOX 15.1 Tips for home visits

Conducting a successful home visit requires assessing the patient, his/her history, current condition, health literacy, family support system, and the physical and social environment. To ensure that health decisions resulting from a nursing assessment focus on an empowered, person-as-partner or PHC approach, it is important to identify people's preferences, needs and values. Such an approach will have a greater likelihood of successful outcomes.

Home visiting requires sensitivity to a multitude of circumstances, including any unexpected situations that have an impact on the nurse's approach to care. Sometimes the visit involves sharing a cup of tea or sitting with a person until they are ready to disclose health issues. In other cases, the nurse's safety may be an issue, particularly if the discussion is contentious or sensitive to family dynamics. The nurse must therefore be aware of all agency safety guidelines, which include learning to 'read' the home situation, and ensuring the vehicle and mobile phone are maintained and quickly accessible A formal risk assessment tool can be used, such as Brennan's (2010) rapid risk assessment tool, or a checklist prepared by their employing agency. Once personal and clinical assessments have been completed, accurate documentation is essential. Documentation is usually completed using the agency proforma to identify the individual(s) assessed and/or treated, and the outcomes, extent and effectiveness of the intervention. Also documented are comments about client satisfaction with care or requests for changes, any diagnostic information including health status, new needs and/or services including those from other care providers, identification of resources and referrals and plans for continuing care. In addition to these formal categories of information, home visiting nurses often record any preferences or features of the home

or situation that may help the next nurse in conducting subsequent home visits.

COMMUNITY, CHILD AND FAMILY HEALTH NURSES

In Australia, despite having a common purpose, there are considerable differences in titles and practices across states and territories for those who provide child and family nursing in the community (Fraser et al 2016). A peak body has been established for all Australian child and family health nurses, called Maternal, Child and Family Health Nurses Australia (www.mcafhna.org.au), with a view towards articulating the role and scope of practice, and ultimately, develop common practice guidelines (Fraser et al 2014, 2016). In New Zealand, child health nurses practise as 'Tamariki Ora' nurses or, for those employed by the New Zealand Plunket Society, 'Plunket' nurses (McMurray & Clendon 2015). In both countries, child health nurses are specialists, guided by the principles of primary healthcare, who provide holistic care to children and their families either in clinics or with home visits. Some child health nurses provide a range of services in primary schools, especially where there is no designated school nurse, and their role includes student screening, health education for teachers and parents and community engagement activities. Another type of specialised child health practice involves acting as the expert resource person in special schools for children with disabilities.

In the clinics, child health nurses conduct developmental assessments on infants and children called 'child health checks', according to government-mandated schedules; however, where there are no child health nurses available, such as in rural and remote areas, these checks may not always be completed. Child and family health practice also includes health promotion and early intervention with vulnerable families, especially where the family has complex needs or there is a need to keep children safe from abuse and/or neglect (Lines et al 2016, Rossiter et al 2016). Although child growth and development is a major focus, working with parents on a variety of family issues includes both targeted and universal services (Fraser et al 2016). This aspect of the role includes psychosocial and clinical support services and referrals as needed. The nurses base their responses on assessment of the child, family and home environment, and often undertake case management, bringing other healthcare professionals in to plan care (Kemp et al 2019). Some nurses work in outreach programs aimed at developing parenting capacity, while others are attached to early learning centres. The population mix in the community can also determine the nurse's focus, identifying local needs as the basis for priorities; such as the needs of migrant and refugee families or those who come from families where one parent is absent for long periods of time through work commitments, for example. In working with these families, health literacy is a major nursing goal, enabling parents to develop the knowledge, skills and coping techniques to nurture their children safely and with good health through their development stages.

SCHOOL HEALTH NURSES

School nursing also focuses on the child and family but also involves the school, its staff and developmental supports (Baisch et al 2011). Comprehensive school health is internationally recognised as a multidimensional role that includes both episodic care to

children and young people and a population approach to health and wellbeing and disease prevention. These dual goals are achieved through surveillance, teaching, health promotion in the social and physical environment through community partnerships, and collaborating on policy development with the school and its community (Bergren 2017, Sanders et al 2019).

In some countries, school health is provided by public health nurses (Sanders et al 2019). In Australia, school nursing continues to evolve, and in 2012, the development of the Australian School Nurses' Practice Standards was a major step towards recognition of the importance of the role (Australian Nursing Federation 2012). New Zealand public health nursing teams and secondary school nurses provide school health services in that country, but without a nationally identified service model or clearly articulated vision (Williams & Dickinson 2017). In both Australia and New Zealand, school nursing has adopted a primary healthcare approach, focusing on assessing students' developmental needs, promoting their health and wellbeing and intervening when they have health problems, all while advocating for a healthy environment in the school community.

School nursing roles are slightly different for primary and secondary school. At both levels, collaboration with teachers, parents and other members of the learning team helps promote academic achievement, which, in turn, empowers students in their journey towards healthy, resilient adulthood. In primary schools the role is focused on ensuring students are safe, healthy and ready to learn. In some cases, the school nurse (SN) provides direct care for children with outbreaks of infectious diseases or with chronic conditions such as asthma, diabetes, obesity or epilepsy (Bergren 2017, Maughan et al 2018). Young children often need health education on preventing diseases by improving hand hygiene, and appropriate techniques for coughing and oral health (Bergren 2017). Increasingly, young people are engaging in risk behaviours and may be suffering from depression, school or personal violence and bullying (Maughan et al 2018). Risk assessment and mental health promotion can therefore be part of early intervention with school age children. This part of the role involves the SN working closely with other professionals such as guidance counsellors and teachers, in teaching healthy behaviours to manage stress, promote good nutrition, and protection from cyber-bullying or other social risks (Fleming & Willoerodt 2017).

Other areas of collaboration include surveillance and monitoring of physical activities, which often sees the SN working with athletics trainers and coaches to monitor sports injuries (Shendell et al 2019). As with other areas of risk assessment, these collaborative roles require strong communication and teamwork skills (Fleming & Willoerodt 2017). Careful documentation is also an important element of surveillance and monitoring, and it encompasses aspects of the 'navigator' role, helping map the links with services and supports along the developmental and learning pathways. Irrespective of whether the nurse is employed by the health service or school, the main objectives are to ensure that students are safe, healthy, able and ready to learn. Priorities change almost daily, depending on individual children's needs, whether they require first aid, help with managing such things as medications, and liaising with teachers and parents (Baisch et al 2011). Other aspects of the role include conducting groups for personal safety, dietary advice or substance abuse prevention, acting as a classroom

resource for teachers who may want expert opinions on a range of health topics and, in some cases, providing immunisations in the school setting for both staff and students.

A large proportion of the secondary school nurse's role lies in dealing with adolescent psychosocial issues such as problems with parental relationships and other issues that affect students' mental health. SNs are involved in helping with such serious behavioural problems as abuse, neglect, depression and violence at school as well as a range of issues arising because of peer pressure (Ramos et al 2013). Peer pressure can be indicated by behaviours such as 'hypertexting', where the student may be constantly vigilant for personal comments from others. Peer pressure can also lead to bullying and stress-related illnesses, including disordered eating and/or obesity. Some students have specific issues related to their social and cultural environment, including immigration or refugee-related problems which can include disruptive neighbourhood relationships that spill into the school community. SNs have to stay abreast of these trends, continually updating their knowledge to understand the psychosocial issues revolving around young people's identity formation, family or group norms. Relationship building is seen as the key to supporting young people, being there at the right time to help them make positive choices when they are confronted with social issues. A cornerstone to building this type of relationship is being sensitive to the changing nature of their social world, whether this lies inside or outside the school.

REFLECTION

List the differences between school nursing in the primary and secondary school setting. What are the common and unique goals of child health and school health nursing?

Like primary school nursing, working in high schools is sometimes reactive rather than proactive, depending on the issues impinging on health and wellbeing, and these situations can require guidance and counselling that involve wider family and community resources beyond the school. Maintaining local knowledge of resources and personal understanding of the student population can expand the role considerably, but this is part of evidence-based practice—the ability to maintain local knowledge as well as research evidence. Most SNs believe it is a privilege to be included in a young person's life, and they work diligently to build trusting relationships with them, their families, their teachers and friendship networks.

OCCUPATIONAL HEALTH NURSES

The scope of practice for occupational health nurses (OHNs) includes workplace surveillance, health education and promotion, case finding and management of occupational diseases, treating employees who are ill or injured, ensuring compliance with workplace health and safety policies and research (Burgel & Childre 2012). A central aspect of the role is the need to act as an agent for the employer while providing advocacy for workers in the setting and a resource for them beyond the workplace (Rogers 2012). The setting may be a single or multi-site organisation, a transient 'place' such as occurs in building construction, a hospital, prison or other custodial context.

OHNs focus on population health in the workplace, practising in partnership with workers and their employers to maintain healthy and safe working practices and a healthy and safe work environment (Rogers 2012). Surveillance is a major part of ensuring environmental safety, aimed at identifying workplace risks. This requires in-depth knowledge of work structures, processes and products, to design injury and illness prevention strategies. Some OHNs who work as part of a health and safety team are able to focus on specific aspects of the nursing role, which may be to provide treatment for injury or illnesses or other health services. Solo practitioners are typically responsible for the broader health and safety requirements as well as managing an on-site clinic. Both roles require diplomacy, especially in situations where the nurse participates with others in lobbying for safe working conditions, which may be costly to the employer. The nurses therefore need high-level communication skills, in-depth understanding of interpersonal and industrial relations, and familiarity with professional and government standards and legislation. Other factors influencing practice include knowledge of the employing organisation, its mission, philosophy and policies, employer–employee relationships, budgetary restraints and familiarity with the professional boundaries of OHN practice. Understanding these aspects of the organisation is helpful in documenting the tangible and intangible benefits of their role (Mastroianni 2017).

In today's workplace it is also relevant to understand the social and cultural impact of corporate policies, including the effect of global markets on worker employment and unemployment risks, and the company's focus on cost-containment and worker productivity. These issues become important in assessing workers' risks, needs and strengths, whether these assessments are for pre-employment screening or to assist them with psychosocial issues that may manifest in the workplace (Burgel & Childre 2012). Other issues that can affect worker stress include the introduction of new work processes, new biological or otherwise hazardous agents in the workplace, increased regulatory mandates or other complex issues that can present barriers to a smooth workday (Rogers 2012).

Surveillance and monitoring in the workplace often involves ergonomic assessments to provide information on the fit between the worker and their work environment. Ergonomic risks can include boredom, glare, repetitive motion, poor workstation–worker fit, lifting heavy loads or tasks that require the worker to assume an abnormal position. Physical hazards can include such things as extremes of temperature, noise, radiation or poor lighting. Biological hazards include exposures to chemical or various biological agents. Psychosocial hazards are those that produce inordinate stress, such as shiftwork, or negative interpersonal relationships on the job, such as bullying and incivility. As with other nursing roles, careful documentation is a pivotal part of the OHN role, particularly when disputes arise over differences in expectations by employers and employees, or when it becomes necessary to demonstrate the measurable value, or return on investment of their services to the organisation (Mastroianni 2017).

The OHN needs to maintain current and high-level skills in first-aid procedures, crisis intervention and trauma management, including threats from workplace violence.

Some nurses maintain a range of health intervention programs to engage workers while they are recovering from an illness episode or injury or to provide care for disabled workers. They may provide employee assistance for those with substance abuse problems, corporate smoking cessation, workplace health and fitness programs or pain management, especially for those with chronic conditions. Successful implementation of rehabilitation or health promotion programs relies on a primary healthcare approach, empowering workers to self-manage, helping them overcome any injuries or disabling conditions without discrimination, ensuring equal opportunity, access to support and inclusion in decision making. These activities require an extensive referral network, including knowledge of workers' general practitioners for timely referrals, which creates an impetus to liaise with general practice nurses.

GENERAL PRACTICE NURSES

General practice nurses (GPNs) have a unique primary healthcare role, where they are employed in a primary care or general practice, at the first point of entry to healthcare. Most are well prepared to provide PHC to the population that attends the practice; however, their role is often constrained by the business model within which they are employed. Traditionally, GPNs have provided administrative and clinical services under the direction of the general practitioners (GPs) in the practice. This works well for the GPs in that they are able to delegate time-consuming tasks to the GPNs. However effective this may be in terms of the business, it is less than optimal in working towards patient-centred care. GPNs are typically highly educated and experienced PHC nurses. Most see their role as helping people navigate through their health service transitions, including holistic care, health promotion, teaching and guidance (Carryer et al 2015, Carryer & Yarwood 2015). Like other PHC practitioners, their goal is to promote integrated, efficient, accessible healthcare (APNA 2017). With population ageing there has been a substantial increase in the number of people with chronic conditions attending general practices. This trend has led to a transformation in the GPN role from providing administrative and clinical services for the practice to a greater focus on health promotion and chronic disease management (Halcomb & Ashley 2019, Halcomb et al 2015).

An evolving body of nursing research has shown that GPN-led services are both feasible and effective in improving chronic condition management because of their health assessment and health promotion skills. They have used these skills in helping people with smoking cessation, diabetes management, cardiovascular care, obesity management and hypertension management (Boyle et al 2016, Stephen et al 2018). Several researchers have described the evolution of the role as having shifted from a predominantly reactive one, to a more proactive role of identifying at-risk patients and helping them with care, goal setting and self-management (Stephen et al 2018, Walters et al 2012). In the UK, there has also been a parallel shift in the role of GPNs, with the trial of a 'link nurse' role, where the GPN provides home visits and telephone follow-up for frail elderly patients (Longstaff et al 2018). Although these nurses work in a different health system than those in Australia and New Zealand, the focus on improving chronic condition management by using GPNs is a welcome innovation, as it provides

recognition of their place in the PHC workforce.

An Australian study of patient perspectives on the GPN role in helping them with chronic condition management showed that patients are both comfortable and satisfied with the nurses' role (Halcomb et al 2015), especially when there is continuity of care through an ongoing relationship with the GPN (Desborough et al 2016). However, because of variations in general practice, some patients are uncertain of the extent of the role beyond assessment (Boyle et al 2016). A New Zealand study of consumer perspectives also found confusion among both consumers and the GPs themselves over the role and scope of practice of the GPN (Halcomb et al 2012). What is evident from this growing body of research is that they are underutilised as PHC practitioners (Halcomb & Ashley 2019, Halcomb et al 2015). This has been attributed to employer preferences, or restrictions due to a lack of funding or education (Halcomb & Ashley 2019). In the general practice business model, the most significant challenge for nurses is to provide care without adding to the cost (Walters et al 2012). This can provide a dilemma for nurses, particularly if they identify unmet needs for patient services or resources that cannot be achieved in the short time of a general practice visit. A Tasmanian study designed to upskill GPNs to provide telephone health mentoring for a COPD cohort resulted in difficulties that led to the withdrawal of GPNs from the program because of the lack of specific financial compensation, workload pressures and competing demands (Walters et al 2012). These researchers concluded that system barriers constrained nurses' opportunities to work to their full PHC capacity (Walters et al 2012). Primary healthcare organisations such as the Primary Health Networks agree that the role should reach its potential, although there has been only limited system-wide policies and practice initiatives to advance the GPN roles nationally (Lane et al 2016).

COMMUNITY MENTAL HEALTH NURSES

Australian and New Zealand community mental health nurses (CMHNs) are recognised as specialist practitioners, and authorised in their respective legislation to practise within a mental health nursing scope of practice. Their work also involves educating other health professionals who may have inadequate experience in dealing with those with mental illness. Like in other types of community nursing, CMHNs work in partnership with their clients and their families to promote recovery from mental illnesses. Their health promotion role is outlined further in Chapter 18. In assisting people with mental health problems, they often use individual case management, integrating physical and mental health goals. The CMHN's specialised skills lie in counselling, health education, care coordination and family and community support for vulnerable people, such as the homeless, those incarcerated or released from custody, or those who are unable to access mainstream health services.

REFLECTION

What resources in your community could be used to support the needs of those with mental illness?

In both Australia and New Zealand, home visits are a feature of CMHN practice. As with other community nurses, in the home they focus on assessing the family environment and support structures in a way that will help people meet their daily living and healthcare needs. Many older people rely on CMHNs to help them cope with the mental health issues of ageing, either directly or in providing expert guidance to nurses actively engaged with them in acute or community settings (Falk & Taylor-Schiller 2019). These needs may include acute medication treatments, working towards continuity of care and prevention of illness and injury (Young et al 2018). In many cases those who seek help from CHMNs have both mental health and substance use issues, commonly known as 'dual diagnosis' clients. Members of this population typically need help for the transitions in their lives, which includes helping with housing and self-help, advocacy and rehabilitation (Hamden et al 2011). CMHNs may be called to assist police, occasionally as part of 'street triage' for those suspected of having mental health issues (Leese & Russell 2017). For those who have been incarcerated, CMHNs may be integral to helping with transitions between criminal justice and health services in their home and community, a role that is critical in successful recovery and prevention of injury or illness (de Andrade et al 2019, Young et al 2018). The main objectives of CMHN interventions are to create a sense of personal empowerment and resilience and, for the community, to educate the public on how best to support those with mental illness in a way that will lead to recovery and positive adaptation to their circumstances (Wand 2013).

Although it is an integral part of the CMHN role, transitional care has become widely recognised as a critical role for all community nurses in guiding people in their healthcare journey across both acute and community settings (Coffey et al 2017). Transitional care includes moving from hospital discharge to home or residential care, or from a community, practice or home setting to hospital. Within transitional care there are some interesting specialised roles that have recently been developed to meet the needs of an ageing population. In New Zealand, an integrated care model has been developed to provide nurse-led, integrated care for those living with long-term conditions. The nurses work in partnership with the patient, family and community as they manage transitions between acute care and other services (Harvey et al 2017). In Queensland, researchers have trialled a nurse-led, physician-championed model of care to improve care for frail older adults presenting to the emergency department (ED) (Wallis et al 2018). Because their Geriatric Emergency Department Intervention (GEDI) model of care was shown to improve care, reduce length of stay and demonstrate cost-effectiveness, the Queensland Government has decided to adopt this model throughout the state. This means that older persons' care will be provided in their homes (including residential aged care) by specially trained geriatric (GEDI) nurses (Queensland Government 2019). This represents an important outcome in terms of older people's health, but also an excellent example of evidence-based nursing being translated into practice. Another transitional care role is that of the nurse navigator.

NURSE NAVIGATORS

Nurse navigators (NNs) are part of a broader group of patient navigators, whose role

has evolved since its inception in the US in 1990 as a way to help disadvantaged and underserved cancer patients receive care throughout their journey through the healthcare system (Freeman 2013). The role has been expanded beyond cancer navigators to the NN role that is quickly becoming part of transitional care in Australia. In this model of care, nurses with a breadth and depth of clinical skills required to monitor high-needs patients and plan the appropriate actions to address these needs help patients navigate through the services and care they need during their health journey (Queensland Health 2019). In Queensland, some NNs are focused on connecting acute or hospital care with that provided in general practice (McMurray & Cooper 2016, McMurray et al 2018). Because of their successes in bridging the gap between primary and secondary care and the high degree of satisfaction by both health professionals and patients, the Queensland Government has rapidly expanded the distribution of NNs across both hospital and community settings.

As with most community nursing roles, a major focus of this role is on continuity of care, and helping people develop the knowledge to be actively involved in their health decisions (McMurray & Cooper 2017). This is a patient-centred approach, where the nurse and patient are partners in care and therefore better prepared to assume control over their healthcare trajectory (Australian Commission on Safety and Quality in Health Care 2014, Hudson et al 2019). Nurse researchers have begun documenting the evolution of this role, describing it as advanced practice on the basis of the nurses' expert clinical knowledge and understanding of the healthcare system (Spooner et al 2019). Coordination of care is an important element of the role, especially in helping overcome existing problems with fragmentation of services. Hudson and colleagues' (2019) qualitative study of patients and carers under the care of NNs revealed that patients saw these nurses as their 'compass' (p 112), and valued the sense of direction they gained from their interactions as they transitioned through various aspects of the health system. The researchers concluded that the role had an impact in reducing stress and creating the potential for both patient and system improvements (Hudson et al 2019). One of these system improvements is better integration of care as indicated in the case study below.

STORY

The nurse navigator for chronic disease management

Over the past four years nurse navigators (NNs) have been a central feature of the Gold Coast Integrated Care Program. The program was based on the premise that people with complex and comorbid chronic conditions are the highest users of hospital care and have many unmet needs. In some cases, their hospital care could be replaced with interventions in general practice, with timely support services from their GP working collaboratively with members of a multidisciplinary team (MDT). As an innovative model of care, the program recruited 15 general practices to work with the MDT to improve service integration and enhance care delivery. NNs were assigned to each practice to help patients with chronic diseases manage their healthcare. The NNs acted as a liaison between the practice staff, clinicians in a community-based Coordination

Centre and those in the hospital and health system. All elements of the program have been part of a broad evaluation (Scuffham et al 2017). Although the final reports are as yet unpublished, the data show high patient and GP satisfaction and acceptance of the NN role. The NNs' interactions with the patients have been invaluable in restoring their sense of empowerment, their capability to self-manage, and their confidence to navigate through their healthcare transitions. The research team concluded that such widespread acceptance could be attributed to their clinical and technological skills, their holistic approach to patient assessment and risk analysis, their ability to intervene with rapid responses to changing patient conditions, and personalised health promotion and case management. The role is being carefully documented to examine the extent to which this level of liaison will promote greater collaborative potential between primary (general practice) and secondary (hospital) caregivers in future.

NURSE PRACTITIONERS

Nurse practitioners (NPs) are advanced practice nurses with Master's-level educational preparation. They are specialists in a diverse range of practice areas, whose scope of practice is determined by respective registration authorities. Despite the variation in practice activities, NPs hold a common commitment to care for populations and communities with advanced knowledge, decision-making skills and clinical competencies. In Australia they must be endorsed by the Australian Health Practitioner Regulation Agency (AHPRA) (Nursing and Midwifery Board 2016). New Zealand nurse practitioners must be credentialled by the Nursing Council of New Zealand Aotearoa (College of Nurses Aotearoa NZ n.d.).

In Australia, NP roles vary according to the different state, territory and regional health agencies employing them (Duffield et al 2011). A comprehensive review of the NP role has shown a lack of consistency in the way the roles are described and implemented, which makes it difficult to link NP activities with patient outcomes (Masso & Thompson 2017). Some NP roles are determined by their educational specialisation, where they may have gained a Master's degree in emergency nursing, paediatrics, gerontology, mental health or oncology, for example. Others may have a more generalist advanced degree, and ultimately practise as a generalist community NP. In New Zealand, some NPs work within the primary health organisations, while others are attached to agencies that require specialist services, such as child health, family planning, sexual health or wound care. A number of NPs have recently been appointed as nurse navigators (NNs) in Queensland.

NPs provide high-level, or advanced comprehensive care for people with chronic conditions (Bonner et al 2019), and those marginalised by economic, gender, age or cultural vulnerabilities (Carryer & Yarwood 2015). As with other PHC roles, the NP focuses on care coordination and collaboration with other health professionals; however, it is a more autonomous role with greater responsibility for clinical decision making than the other community roles. Frost and colleagues (2018) conducted a study of patient perceptions of the role, concluding that NPs are seen as enabling and highly valued, due to their personal consultation approach and in the time taken to provide holistic care using a partnership or PHC approach. This high level of satisfaction with

the role has also been reported in relation to specialist mental health NPs and those working with chronic disease patients (Bonner et al 2019, Harvey et al 2018). A study of NPs' perceptions of their role indicates that they see themselves as addressing healthcare access gaps as well as providing specialised services, such as emergency care (Clifford et al 2019). These researchers concluded that, in future, the role should reflect a careful balance of generalist and specialist roles in a way that would better serve workforce needs as well as those of the population (Clifford et al 2019). This may be the challenge for all community nurses, given the need to work towards best practice in providing both targeted and comprehensive PHC.

Goals for community health

In all community nursing roles, it is important to practise within the appropriate scope of practice and be guided by the principles of primary healthcare to achieve good health for the population and the community itself. This is accomplished through the following nursing actions:

- basing plans on assessment of people in the context of the community as a basis for promoting equity of access to continuity of healthcare and to community capacity building

- encouraging empowerment of the population by adopting an inclusive, partnership approach to planning, ensuring authentic communication that will help people make their views, goals, preferences and priorities understood

- adopting a culturally safe and appropriate approach to planning, which requires knowledge of the nurse's own and others' cultural preferences, norms and conventions

- using appropriate technologies so that interventions are affordable, achievable and fit for the population

- including other sectors such as education, transportation and environmental plans in planning for community health

- acting as an advocate for the community with knowledge of structures, supports and policies governing people's lives, such as those determining support for medical, disabling and social needs and the communication skills to convey these to all levels of the population in a way that is readily understood.

CONCLUSION

Nurses practise in many different settings to achieve common and sometimes unique goals, depending on the population and the community. To help a community through such a multilayered, multidimensional role illustrates the notion that high-quality, safe care for communities and the people who live there can only be achieved when the context of care is carefully considered in conjunction with the specific health issue, and the broader circumstances of the people's lives are being addressed. This geographic, cultural and socially embedded nature of community nursing makes it one of the most rewarding roles in nursing.

REFLECTIVE QUESTIONS

1. Describe the roles of nurses in maintaining healthy communities.
2. What strategies would you use to promote a healthy community?
3. What clinical skills do you think are most important in community nursing?
4. What general skills are required for community nurses to work across different settings?
5. Are the principles of primary healthcare achievable in all community nursing roles? Which roles might be more challenging in this respect?

Recommended readings

Australian College of Nursing, Community and Primary Health Care Community of Interest Group. (www.acn.edu.au/cphcnw)

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CHAPTER 16: HEALTH DISPARITIES: THE SOCIAL DETERMINANTS OF HEALTH

Denise Wilson and Stephen Neville

KEY WORDS

colonisation; deficit; differential; access; discrimination; explanations; health disparities; inequalities; inequities; intersectionality; poverty; quality of care; racism; rights; social; determinants of health; social justice; victim blaming

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- explain what health disparities are and how they are similar to or different from inequalities, disparities and inequities;
- discuss how social determinants of health, such as colonisation, racism, poverty and family violence, impact access to health services and health outcomes;
- explain the impact of differential access to social determinants of health, access to health services and quality of care;
- discuss why listening carefully to the needs of people with health disparities is essential for quality nursing care;
- explain how a social justice, equity and intersectionality framework can assist nurses in understanding and responding to the needs of people living with health disparities.

INTRODUCTION

In this chapter, we explore health disparities and the various factors influencing the quality of health services needed by people belonging to marginalised groups. We use the concepts of social justice, equity and intersectionality to explore ways to engage better with people. The focus will be on Indigenous peoples, older people, those belonging to the LGBTQI (lesbian, gay, bisexual, transgender, queer and intersex) community, families affected by violence, and youth.

Nurses can encounter people who live with worse health status and outcomes than other people living in their communities and country. Instead of receiving quality care to address their health disparities, those belonging to marginalised groups often encounter discriminatory behaviours and attitudes and are negatively stereotyped when seeking health services (Cormack et al 2018). The health disparities that people experience are often reflective of wider social inequities and a lack of access to the wider determinants of health. While health disparities can impact people's access to health services, determinants of health are invariably beyond the control of nurses to make a difference. Nurses can positively influence timely access to, and engagement with, health services and the quality of care people receive.

Health disparities

Disparities, inequalities and inequities are terms commonly heard throughout the health sector. Nurses can inadvertently perpetuate these by lacking awareness and understanding of health disparities that exist for various groups within their community (Rooddehghan et al 2019). This also increases the possibility of becoming complacent and 'normalising' some people's poor health status and outcomes. Importantly, this can lead to overlooking their specific health needs.

Some disparities are justifiable and expected, while others may relate to cultural expectations. For instance, inequalities such as sex-related conditions are acceptable—women are more likely to have breast cancer whereas men will have prostate cancer and women will not. In some cultures, being overweight is a sign of affluence and that the family is doing well. However, many persistent disparities and inequalities affecting groups of people in our communities are considered unfair and unjust, such as Indigenous peoples, older people, youth, those who identify as LGBTQI, and those living with family violence. These groups of people are marginalised within our health systems because the focus is on meeting the needs of the majority, often in a way that is informed by the dominant worldview and culture. The outcome of such healthcare delivery does not recognise the specific requirements of those on the 'margins'. The health inequalities that we are referring to here are '… systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and society. However, these differences are preventable and, as such, considered to be unfair and unjust' (Hemingway & Bosanquet 2018).

Health disparities are those differences evident in the health status and outcomes between various groups of people within a community, based on age, gender, ethnicity, race, sexual orientation and socioeconomic status. Health equity means efforts are made to eliminate the health disparities linked to social disadvantage (Davis & Chapa 2015). Differences also exist in people's access to and engagement with health services, and the nature and quality of healthcare received (Henderson et al 2018, Wasserman et al 2019).

Not everyone has equal opportunities to access quality healthcare. Healthcare providers' discriminatory attitudes and the ways in which they approach the delivery of a person's healthcare can contribute to their feeling uncomfortable or avoiding future needed healthcare. For example, when a nurse omits or does not offer a person an aspect(s) of healthcare that others receive, or who speaks to an individual in an indifferent or offensive way (Fitzgerald et al 2017). As a consequence, those experiencing disparities exposed to a healthcare provider who treats them in a discriminatory manner may avoid timely contact with needed health services (Hall et al 2015, Wilson et al 2018). Avoiding accessing healthcare services then leads to preventable and unnecessary hospitalisations or deaths. Blaming individuals does not explain why they are not proactively seeking health services in spite of their negative experiences (Hall et al 2015).

REFLECTION

Think about the people in your local community.

1. Do any one or more groups of people (e.g. belonging to distinct ethnically or socially based groups) experience health disparities and inequities in their healthcare or health outcomes?

2. How do these inequities compare to the national profile of these groups?

3. In what ways may they be treated differently when accessing health services?

Framing disparities within a social justice–rights–equity nexus

The World Health Organization (WHO) (2017) explicitly states every human being has the right to '… the highest attainable standard of health as a fundamental right …'. The WHO stresses the need for quality health services that avoid discrimination to be sufficiently available, accessible to everyone, ethnically and culturally acceptable, ensuring all people have human rights, and that health service providers are accountable for ensuring people's rights are respected.

Some groups of people have additional rights to health. For instance, Indigenous peoples have the United Nations (UN) Declaration on the Rights of Indigenous Peoples (UNDRIP) passed in 2007, although not signed by Australia and New Zealand until 2009 and 2010, respectively. In New Zealand, Māori have rights afforded under Te Tiriti

o Waitangi—a treaty between the government and Māori. Youth have rights under the United Nations Convention on the Rights of the Child (UNCRC). Despite these various rights existing, for those living with social and health inequities they are applied inconsistently or not observed. While there are no formal international declarations on the rights of older and LGBTQI peoples, the United Nations has highlighted the human rights challenges for both groups and promotes addressing violations (see Office of the High Commissioner for Human Rights, United Nations Human Rights website http://www.ohchr.org/).

Social justice relates to the equitable distribution of resources that enable people's optimal health and wellbeing and full participation in society (Buettner-Schmidt & Lobo 2012). Treating people equitably is underpinned by social justice; equity is the right to health and to optimising equal health outcomes. The Health Quality & Safety Commission (HQSC) (2019:47), cites the Ministry of Health, saying, 'Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.' Ideally, by treating everyone fairly, using different approaches, upholding their rights, and achieving equity, all groups of people should be able to reach their health potential.

Particular groups bear the burdens associated with health inequities, which are not shared by everyone. They are both avoidable and unjust (Wilson et al 2018), but occur because of:

- variations in health status and outcomes that affect a particular group(s), consistently seen in patterns of difference in morbidity and mortality rates and higher levels of socioeconomic deprivation
- social processes (social, economic and environmental policies, for example) that privilege some groups of people over others, and
- biased and discriminatory practices leading to the unfair distribution of resources and opportunities (Whitehead 1992).

However, by nurses being sensitive to people's realities and life contexts affected by inequities, aspects of inequities are potentially modifiable. Nurses can also question dominant discourses within our society and, more specifically, within the health arenas they work within. Examples of dominant discourses are:

- 'Everyone has equal opportunities', or
- 'Everyone has equal access to healthcare services—some choose not to access them.'

Such statements overlook the challenges some groups of people face in their everyday lives, making it difficult or impossible to capitalise on opportunities or to access healthcare services. For instance, mothers affected by socioeconomic deprivation or

poverty, raising their children on their own, may prioritise their money on feeding their children rather than on the costs associated with accessing health services. Also, people identifying as LGBTQI may perceive healthcare services are not readily accessible because they fear being judged or discriminated against because of their sexual orientation, and those delivering the services will not understand their needs.

REFLECTION

1. Treating everyone the same or equally does not guarantee equal outcomes or equity. Discuss with your peers why this may be so.

2. Some minority or marginalised groups aspire to having more than the same health outcomes as other population groups; that is, beyond health equity. They aspire to wellbeing as their end-goal. Discuss how wellbeing would be a loftier goal than health equity.

Social determinants of health

Social determinants of health are those factors known to protect people's health and contribute to getting the right healthcare they need. But not all people have the same access to these important determinants of health, to healthcare services, or quality healthcare, each of which can influence health status or health outcomes. Fig. 16.1 shows health inequities occur anywhere along a healthcare continuum. Inequities include not having necessary determinants of health (such as those listed), and experiencing differences in access to healthcare services influenced by discrimination, socioeconomic status, previous adverse health experiences or cultural beliefs and practices that differ from those of the health service. People belonging to minority groups can also experience differences in the quality of care they receive, evident in adverse events rates, and differences in length of stay in hospital from those with similar conditions (Wilson et al 2018). Having a university education, being employed, having enough money, feeling safe in your community and feeling connected to friends and family are all social determinants of health. We know those with reduced health outcomes are likely to have less education, be unemployed or employed in jobs with inadequate incomes and live in sub-standard housing. Furthermore, discrimination and racism severely restrict people's job and shelter opportunities and the quality of healthcare they may receive (Braveman & Gottlieb 2014). Indigenous peoples' colonisation and subsequent disconnection from their traditional land, language, cultural practices and ways of life negatively impact their health—effects that persist across generations (Australian Indigenous HealthInfoNet 2019, Cormack et al 2018, Ministry of Health 2015, Paradies 2016).

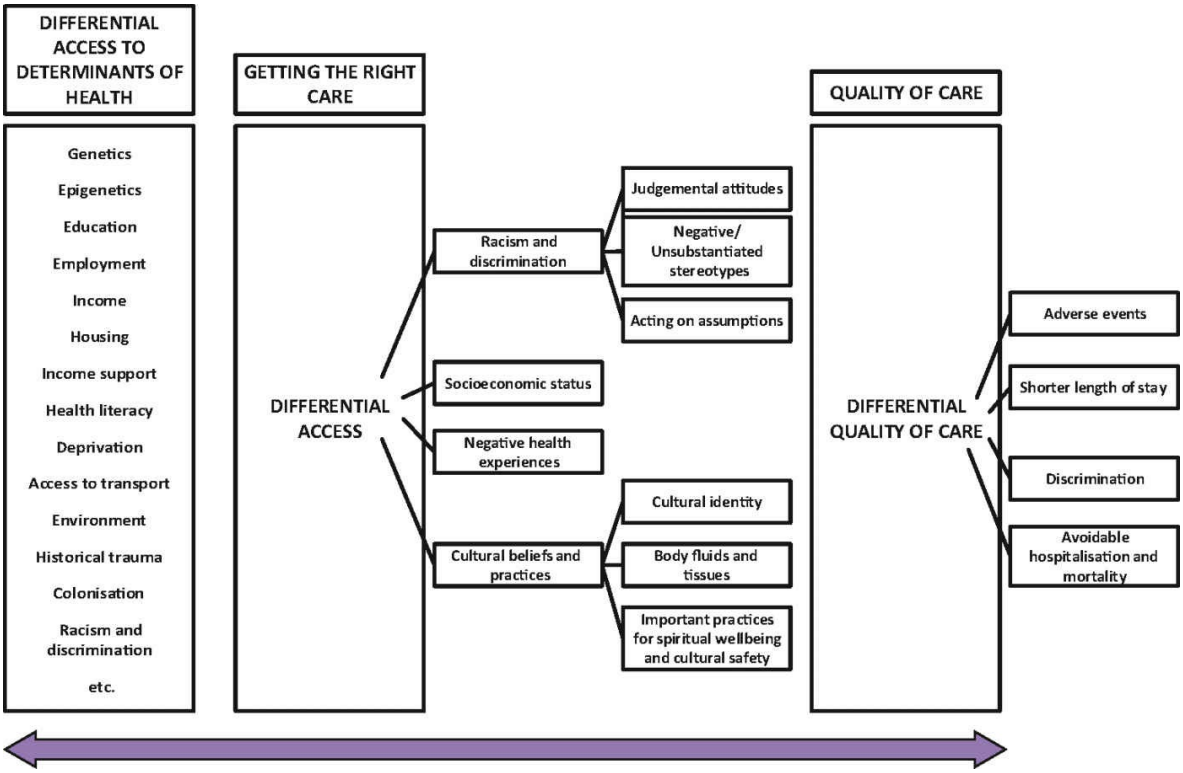

FIGURE 16.1 Pathways to health inequities

Environment counts! Evidence shows children growing up in homes with poverty, family violence and regular exposure to discrimination have their short- and long-term health adversely impacted. These children are more likely than those without poverty to have chronic physical and psychological health condition(s) in adulthood and die prematurely (Bryan 2019). Epigenetic research demonstrates the environments people live in can create epigenetic changes that either activate or suppress gene expression. Godfrey and colleagues (2011) found pregnant mothers with poor nutritional status led to epigenetic changes in their baby's genes responsible for metabolic control. These changes resulted in their children being at risk of obesity and metabolic disease in later life. The trauma associated with colonisation is likely connected with epigenetic changes (Conching & Thayer 2019).

Often people experiencing marginalisation are disregarded on more than one basis; for instance, someone who is Indigenous, a young woman and who identifies as being lesbian may be marginalised based on their indigeneity, gender and sexual orientation. Poverty and unemployment may be additional factors compounding the total effect of being marginalised. These impact access to not only healthcare services but also the quality of healthcare.

Effects of disparities in healthcare

Intersectionality is useful to explain the multifaceted effects of multiple forms of marginalisation shaping people's daily lives, and their suboptimal access to necessary social determinants of health (Bauer 2014). The usual rhetoric that all people have equal

access to healthcare implies equity exists and where it does not these people choose not to avail themselves of the opportunities afforded to them. But as we have discussed, this is far from their reality. They need compassionate and empathetic nurses who understand the challenges and barriers they face.

Marginalisation occurs in various forms and is evident in societal inequities related to gender, race and ethnicity, age and access to necessary socioeconomic determinants of health (such as income, employment, education, reliable transport and telephones). Any form of marginalisation can negatively impact people's timely access to needed healthcare services; that is, being able to seek help before their health conditions become more acute and chronic. It is important to understand that these multiple forms of marginalisation do not present singly, but instead have compounding effects (Bauer 2014). Furthermore, observations of differences in groups like Indigenous peoples in access to, and quality of, healthcare resulting in a sub-standard quality of care include adverse events or unplanned readmission to hospital (Best and Fredericks 2014, Rumball-Smith et al 2013).

People's social contexts assist in shaping their health and wellbeing, yet within our wider Western-influenced societies a persistence exists in explaining health disparities regarding individuals' responsibilities and obligations. These explanations are frequently presented as false negative stereotypes that are deficit focused, negative and, as such, support victim blaming. Fundamental to reducing health inequities and promoting access to needed services and the quality of care delivered, health practitioners, like nurses, should avoid blaming individuals by using unhelpful explanations (such as negative stereotypes) or deficit accounts. Countering such references is achieved by having a critical understanding of the socioeconomic and community contexts and nature of health inequities that exist for the various groups (see Table 16.1 for examples).

TABLE 16.1

Dispelling deficit explanations

DEFICIT EXPLANATION	EVIDENCE
Deficit explanations are ways in which people belonging to particular groups have their health and social status explained.	**Research that shows us the realities for marginalised individuals who are in our health systems.**
'Poor people could eat better if they managed their money better!'	Research on the affordability of food demonstrates that rent and food consume almost half of people's weekly incomes when living in the most deprived neighbourhoods (Barosh et al 2014).
'A woman living with family violence should just leave. If this woman doesn't, she must be okay	New Zealand death reviews show that women living with family violence cannot just leave. Instead, they are entrapped in the relationship by a violent partner who uses strategies, such as coercive control, manipulation, threats to their wellbeing and life (and their

with it!'	children's) and social isolation. Consequently, they do not have the necessary autonomy and agency to leave (Family Violence Death Review Committee 2016).
'[Indigenous] people spend all their money on smoking and gambling instead of feeding their kids well and correctly. They just need to get their priorities right.'	While there may be some Indigenous peoples who gamble and smoke, the evidence overwhelmingly shows that most Indigenous people reside in neighbourhoods with high deprivation (poverty), and struggle to provide the basic needs for their children on a daily basis (Bécares et al 2013).
'Young people are fit and healthy and do not need health services.'	Contrary to this statement, young people's unmet health needs include a broad range of health and social issues, including difficulty accessing appropriate and youth-friendly services (Cheetham et al 2013, Forward 2015).
'Older people are dependent, cannot live on their own and should be cared for in residential care facilities.'	While some people live in residential care, overwhelming evidence suggests 'ageing in place' or living in their home improves physical and mental health and promotes independence (Van Dijk et al 2015).
'LGBTQI people are mentally ill.'	Identifying as LGBTQI is not a mental illness but mental health issues in these groups are relatively high, usually as a result of the stigma and discrimination experienced for not identifying as heterosexual (Ellis et al 2015).

REFLECTION

Complete the following reflective exercise to determine the thoughts, biases and assumptions that you hold for each of the groups of people (Indigenous peoples, older people, those belonging to the LGBTQI community, families affected by violence, and youth). Identify where you need further development than is discussed in this chapter. Use this opportunity to be creative and note that there are no right or wrong answers.

- What I think about [the particular group] is …
- What I feel about [the particular group] is …
- What I know about [the particular group] is …
- What I need to know about [the particular group] is …

Responding better to those belonging to groups commonly affected by disparities

INDIGENOUS PEOPLES

Globally, Indigenous peoples experience inequities in their healthcare compared with other groups living in their respective countries, related to the ongoing effects of colonisation, discrimination and their access to necessary socioeconomic determinants

of health. Social and historical circumstances make them targets for negative stereotypes and deficit explanations. The realities of their everyday lives make it difficult to access healthcare because, for example, many do not have access to reliable personal or public transport, or their experiences with healthcare providers have often been negative (Best & Fredericks 2014, Wilson et al 2018).

The Indigenous peoples of both Australia (Aboriginal and Torres Strait Islanders) and Aotearoa New Zealand (Māori) were prosperous and healthy people before the settlement of their countries by settlers. As a consequence of Indigenous colonisation, people were systematically depopulated, disconnected from their land, cultural knowledge practices, and language and became disenfranchised socially and economically. They became minority groups within their countries. Furthermore, forcible removal of Indigenous children from their families occurred—for example, the 'stolen generation' in Australia. As a result, Indigenous peoples are affected by historical trauma, which has led to the transmission of this past trauma across the generations (Pihama et al 2014, Treloar et al 2016), aided by the loss of their cultural identity and connections, and their consequent assimilation. They have become socially marginalised and forced to discard their cultural ways of being in favour of new dominant cultural practices.

Indigenous peoples of Australia and Aotearoa live with notable social and health disparities compared with other people residing in their respective countries (Sherwood 2013). Also, they are more likely to live with high levels of socioeconomic deprivation, develop non-communicable diseases (such as diabetes and cardiovascular disease) at younger ages and live with greater levels of ill-health and disability and die prematurely. They are also less likely to access primary health services, instead over-represented in the avoidable hospital and mortality statistics (Ministry of Health 2015). While Indigenous peoples tend to be youthful populations, they are dying of diseases commonly associated with older age before they are 65 years of age. They have shorter life expectancies: 10 years for Australian Indigenous peoples (Australian Indigenous HealthInfoNet 2019), and seven years for Māori in Aotearoa (Ministry of Health 2015).

Taking a person-centred approach to practice is crucial for working with Indigenous peoples to ensure consideration of their life circumstances when planning care (Wilson et al 2018). Culture is important. Cultural identity and connection are protective factors to a certain degree; therefore, providing culturally responsive care is important for Indigenous peoples (see Box 16.1). Such care provides nurses with a frame of reference to understand Indigenous peoples' worlds. In contrast to the biomedical model evident in many health services, Indigenous worldviews are holistic, relational, spiritually and environmentally based. This multifaceted concept of health means Indigenous peoples' spiritual wellbeing and family are of utmost importance. Establishing respectful relationships and a partner-in-care approach is important—this should begin by saying where you are from and who you are. Recognising the significant role and obligation family plays in an Indigenous person's healthcare journey is important. Recognise the different health priorities an Indigenous person and their family might have from those of the health professional. For example, housing may be more important than the individual's health condition.

BOX 16.1 Culturally responsive practice

Culturally responsive practice involves nurses being culturally competent and providing culturally safe care for the Indigenous person and his or her family. Wilson and Hickey (2015) identified three components (KAI) to culturally responsive practice:

Knowledge	Identify personal, cultural values, beliefs, practices, assumptions and biases held about marginalised groups in your community and how these may impact on your practice. Critically understand the historical, socioeconomic and political influences affecting their health and wellbeing.
Action	Establish respectful and non-judgemental relationships. Recognise the health (and social) needs of the person and their family. Avoid imposing your personal and professional values and beliefs on individuals and their family. Identify people's and the family's strengths and existing health-promoting behaviours and use these to inform plans of care.
Integration	Include important cultural needs in an individual's care plan. Including cultural needs may require getting the assistance of a cultural advisor who understands their particular culture needs.

OLDER PEOPLE

The world's population is ageing and this is particularly evident in Westernised countries. Contributing factors include decreases in global fertility and mortality rates. Other factors include advances in science and healthcare, improved standards of living, including improved nutrition and the implementation of public health measures such as the availability of clean water. In line with other Western societies, the receipt of superannuation marks the time when a person transitions from middle to old age. In New Zealand and Australia, this is currently 65 years, although Australia has passed legislation raising the eligibility to receive superannuation incrementally to 67 years by 2023.

Santrock (2017) identifies three categories used to describe the older age group: young old (those aged 65–74 years), old (those aged 75–84 years) and the oldest old (those aged 85 years and over). Ageing is not viewed positively in Western societies and being 65 years or over potentiates this group of people to discrimination, called ageism. Ageism is a term used to describe the negative and stereotypic bias resulting in older people's first-hand experience of society's bigoted views about being older (Burnes et al 2019). There is a significant body of research-based literature that negatively links being old to increased frailty, being dependent and not being able to live on their own, forgetful and cognitively impaired, as well as being an economic burden on society (Ausanee & Duangjai 2019). While this may be true for some, it does not relate to all older people (Rodgers et al 2017).

Negative views on ageing are picked up by the media and translated into our everyday conversations. An example is referring to the ageing population as a 'grey tsunami'; tsunami evokes visions of death and destruction. Viewing older people in this way moves ageing from being a natural human process to positioning this group of people negatively, and old age as a burden on society. The consequences are significant regarding mental health and wellbeing. Studies reported that older participants who

feel discriminated against based on how old they were had poor psychological wellbeing including stress, depression and low scores in self-rated health (Burnes et al 2019).

Negative societal attitudes to older people have also infiltrated the delivery of healthcare services to this group of individuals. Nursing research has shown that if you are older and hospitalised, especially if you are a vulnerable older adult, you may not receive active treatment or respect, could be assigned a nurse who is less experienced and could be spoken to as if you were a child (Koskenniemi et al 2015). As nurses have the most contact with older people in comparison with other health professional groups they are well placed to be instrumental in reducing ageism. As identified in the previous section, taking a person-centred approach to working with older people is pivotal to reducing inequities and, as a result, improving their outcomes. Person-centred care recognises the individual's uniqueness and includes the person and their family or significant other as active participants in the care process (Kitson 2018). By taking this approach nurses can advocate for older people to:

- ensure older people are not treated as a homogeneous group—there are generational differences between a 65- and a 90-year-old
- replace terms like 'elderly' with 'older people' to avoid ageist connotations
- remember that many older people remain active and live independently, while some live with dementia and frailty.

LGBTQI PEOPLE

Throughout many parts of the world, anti-discrimination laws have been passed promoting equality for same-sex attracted, gender dysphoric and intersex peoples. Historically this has not been the case. LGBTQI people were classified as criminals and deviant resulting in them being imprisoned or admitted to psychiatric institutions (Taliaferro & Muehlenkamp 2017). However, despite advances in civil rights, homophobia, transphobia and not understanding what being intersexed is remains an issue. Consequently, discrimination of these groups occurs in both subtle and overt ways.

A subtle form of discrimination is assuming everyone is heterosexual (referred to as heterosexism). For example, asking a man as part of a health screening questionnaire about his wife. Another assumption is being assigned a 'gay' label if you are not heterosexual. Such labelling does not take into account the different expressions of sexuality and gender that exist amongst LGBTQI people. More overt forms of discrimination are refusing to call a transgendered person by their preferred name, instead insisting on using their biologically assigned name or requiring transgendered people to use public restrooms by anatomy rather than identity.

Negative experiences and discrimination of these groups of individuals have been shown to result in significant social and health disparities, particularly mental health

issues. When compared with the general population, people identifying as LGBTQI experience an increased risk for substance abuse, anxiety disorders, depression, self-harm and suicide (Taliaferro & Muehlenkamp 2017). Also, due to negative attitudes towards LGBTQI individuals by health professionals, including nurses, these groups may be reluctant and fearful to seek healthcare. Consequently, this is a significant barrier to receiving timely, preventative, health-promoting and intervention-related health services (Sherriff et al 2019).

There are many ways nurses can be more responsive to LGBTQI people that can have a significant and positive effect on their wellbeing:

- Become knowledgeable about the diversity that exists within LGBTQI communities and the specific health and social service needs of these groups.
- Be aware of the multiple ways that discrimination (subtle and overt) impacts on LGBTQI people.
- Understand the social and health effects resulting from discriminatory attitudes and practices.
- Have skills and attributes to engage meaningfully with LGBTQI individuals.
- Be able to put aside your views and prejudices to provide a person-centred and culturally appropriate healthcare service.
- Ensure the workplace is LGBTQI friendly. Friendly workplaces include making publicly visible health and social service information relating to LGBTQI communities.
- Develop partnerships with LGBTQI organisations to provide support and education opportunities for staff and to refer LGBTQI people to appropriate social support agencies as required.

FAMILIES AFFECTED BY VIOLENCE

Globally, one in three women have experienced intimate partner violence and, for the Indigenous peoples of Australia and New Zealand, the prevalence of violence within their families is much higher (Aboriginal & Torres Strait Islanders Social Justice Commissioner 2015, Fanslow et al 2010). Family violence affects both adults and children, extending beyond intimate partners to other family members. It significantly has an impact on a person's long-term physical, psychological, spiritual and social health and wellbeing (Sugg 2015). Children are affected by family violence—living in

homes where violence occurs has harmful effects and is considered child abuse and neglect. Family violence and child abuse and neglect are considered adverse childhood experiences, and nurses have a role in safeguarding children (El-Radhi 2015, Reichman et al 2018).

Evidence indicates women and child victims of family violence often go unrecognised by health professionals and their pleas for help are disregarded (Family Violence Death Review Committee 2016). While some evidence indicates men and women are equally violent, intimate partner violence is predominantly a gendered issue because male partners inflict more severe and lethal violence (Family Violence Death Review Committee 2017).

Family violence and women not leaving violent partners is shrouded in misconceptions. Nurses need to understand family violence is a long-term pattern of abuse concerning one person's intentional infliction of physical, psychological and sexual violence (or a combination of these) onto another person. Perpetrators entrap women and their children in their relationships by using coercive control and threats on their life and wellbeing, social isolation, manipulation and unpredictable violence. Their pleas for help often go unheeded, aided by the indifference of those in 'supporting services' (Family Violence Death Review Committee 2016, Wilson et al 2015). Victims of family violence lack the necessary autonomy and agency to fix their violence—they need the help of health professionals, like nurses, to help them to be safe and to protect their children. Nurses can help by:

- being genuine and having a non-judgemental and helpful manner
- becoming knowledgeable about family violence dynamics and understanding common misconceptions that are unhelpful
- understanding the time leading up to and after leaving a violent relationship is dangerous for victims and their children, with an increased risk of homicide around this time
- reviewing the language used and fully and accurately recording the victim's story
- knowing organisational policies for making a referral, and helping a victim to contact people rather than just providing a name and contact details, information leaflets, or a safety plan (Wilson et al 2015).

YOUTH

Well, healthy young people are vital to the health, wellbeing and productivity of our communities and respective countries. The health needs of many young people can be unmet despite facing a variety of known health needs. For instance, mental health issues (including depression and suicide), sexual health (including teen pregnancy and

sexually transmitted infections), alcohol and substance use, obesity, physical activity, motor vehicle accidents and life-threatening illnesses. For instance, Indigenous youth substance misuse and binge drinking is associated with poorer health and social outcomes (Azzopardi et al 2018, Clark et al 2013). The reasons for unmet health needs can relate to lack of access to healthcare services.

An Australian study found most adolescents do not seek healthcare, despite having health issues (Booth et al 2004). Reasons for young people not accessing health services include having confidentiality concerns, a lack of knowledge about available services, being uncomfortable disclosing a health issue, or complicated processes to access services (Booth et al 2004, Horsfield et al 2014). Often young people's input and visibility in health services may be absent. For example, not including a young person in decisions made about their health and wellbeing or not participating because of perceived barriers such as staff friendliness.

Young people are not a homogeneous group—they are diverse. There is a significant difference between how a 14-year-old understands and interacts in the world compared with a 20-year-old. Therefore, co-reviewing delivery of services to young people is essential in creating youth-friendly services—importantly, creating an environment and having age-appropriate and friendly staff (Blignault et al 2016, Hutton & Jackson 2014).

There are some things nurses can do in their practice to improve responsiveness to youth (Cheetham et al 2013, Forward 2015):

- getting feedback from young people about what is 'youth-friendly'
- ensuring young people are involved in decision making about their health

STORY

Jonathan is a 76-year-old retired builder who has recently had his hip replaced after living with increasing pain and immobility over the last three years. Six months ago, Jonathan's wife Ella passed away following a 10-year battle with breast cancer. During Ella's last few months, Jonathan cared for her. They have three children and 16 grandchildren, although they live considerable distances from Jonathan meaning he rarely gets to see them. The general practitioner is concerned about Jonathan's overall wellbeing and has asked you to visit him in his home to assist with his healthy ageing.

Using knowledge about healthy ageing (see Neville et al (2018) in the recommended reading list) and the KAI approach to culturally responsive practice, consider the following.

- being clear about confidentiality and consent issues
- listening attentively and respectfully
- being flexible and using a range of approaches
- having discussions about recovery

- communicating clearly and providing meaningful information.

CONCLUSION

Those groups experiencing health disparities belong to marginalised groups within their communities. They face inequities in their access to and engagement with healthcare services, including the quality of care that they receive, despite health being a fundamental right of all people globally. Underpinning practice with health equity, social justice and intersectionality ensures people receive care that is fair and just, and are not subjected to deficit explanations and discriminatory attitudes and behaviours. By attending to the quality of care that they deliver, nurses can contribute to the reduction of health disparities.

REFLECTION

Refugee and immigrant groups, like the groups of people introduced in this chapter, are also at risk of not having their needs met. Discuss with your peers the things that you will need to (a) be mindful of and (b) include in your practice when working with people who belong to refugee and immigrant population groups. What do nurses need to consider when working with these groups of people and their families to ensure safe and quality care?

Reflective questions

Knowledge

1. What are the assumptions and biases you hold about older adults in similar situations as Jonathan?
2. What do you know about the realities for older men? What do you need to know?
3. What do you need to understand about Jonathan's health and wellbeing needs?

Actions

1. What things do you need to consider to establish an effective relationship with Jonathan?
2. How would you go about engaging with Jonathan?

Integration

1. How would you go about identifying Jonathan's needs as an older man?
2. Given that Jonathan appears to be somewhat disconnected from his family, what things do you need to consider to strengthen his social and family connections and supports?

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CHAPTER 17: MENTAL HEALTH PROMOTION

Wendy Cross

KEY WORDS

community; mental health; health; health promotion; mental; healthcare; mental illness; nursing; population

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- identify mental health-promoting opportunities in nursing practice;
- state factors that may impede health-promoting nursing practice;
- describe health promotion strategies that nurses and other healthcare professionals may use;
- explain effective health promotion approaches for working with people who have a mental illness using a recovery-oriented approach;
- implement strategies for promotion, management and prevention in mental health.

INTRODUCTION

Health is defined by the World Health Organization (WHO) (1946) as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The absence of physical disease or a mental disorder does not necessarily equate to good health. According to Prince and colleagues (2007) there is no 'health without mental health'.

High rates of mental disorders are reported around the world. The Australian Institute of Health and Welfare (2018) reported that 2–3% of Australians have severe mental disorders. A further 4–6% (about 1.5 million) have moderate disorders, and 9–12% (about 2.9 million) have mild disorders. Earlier, the 2007 National Survey of Mental Health and Wellbeing found that one in five Australian adults had a mental health issue in the previous 12 months and that almost half the total Australian population would experience a mental health issue at some time in their lives (Australian Bureau of Statistics 2007).

Similarly, nearly one in five adults in the USA in any one year are affected by mental disorders (National Institute of Mental Health 2019). Over 7% of the global burden of disease as measured in DALYs (disability-adjusted life years: years lost of healthy life) and 19% of all years lived with a disability has been attributed to neuropsychiatric disorders (Rehm & Shield 2019).

Mental health, physical health and social wellbeing are intertwined with recent research focusing on the physical health of people with severe mental illness and reduced life expectancies. People with severe mental illness are at increased risk of developing physical health diseases (e.g. diabetes, cardiovascular disease, obesity) and health promotion programs are a noted priority for improvement (Ehrlich et al 2015, O'Brien et al 2014). Other co-morbidities such as illicit drugs and excessive alcohol consumption are also noted to be much higher in people with severe mental illness (Horsfall et al 2009, Lai et al 2015). These types of challenges need to be addressed among different populations, including early prevention programs with children (Tomaras et al 2011). This makes 'good' mental health everybody's business.

In this chapter, mental health promotion is discussed, including how the nursing profession can develop and support effective mental health promotion programs consistent with a recovery-oriented approach seeking to decrease health inequalities. In the next section, population health is overviewed, shifting the emphasis from the individual to the group.

Population health

Population health has been defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group' (Kindig & Stoddart 2003). Population health signifies a shift in emphasis from the individual to the group. It is also broader than general public health because it has a larger scope to include all factors known to influence the health of different populations.

The study of population health concentrates on investigating health in communities with the aim of improving health and wellbeing using a variety of mechanisms that address the inequalities in health status between particular groups within that community. Many population subgroups do not have the same health status as the general population. These are classified as priority population groups.

The Australian Institute of Health and Welfare (see the Australian Government website, www.aihw.gov.au/) provides up-to-date data in order for population subgroups identified as requiring specific interventions to have health promotion efforts directed towards them. Likewise, *Healthy People 2020* is a website supported by the US Department of Health and Human Services (see www.healthypeople.gov/). It identifies a number of areas deemed to be social determinants of health with associated goals to enhance population health. Both organisations provide links to the research evidence.

Various strategies have been adopted throughout the world. In New Zealand, for example, there are a number of health promotion activities that target population health. For example, Whānau Ora is a program cooperatively implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development. This program places families/whānau at the centre of service delivery, and involves the combination of health, education and social services to improve overall outcomes for New Zealand families/whānau (see Whānau Ora program in the 'Online resources' at the end of this chapter).

Social determinants of health

Social determinants of health include many factors: social, environmental, cultural and physical that various groups are born into, grow up and function with over their life which have a quantifiable influence on their health. The WHO's Commission on Social Determinants of Health (2008) reported that these factors were responsible for the majority of health inequities across the world.

The social determinants of health are the circumstances in which people live. They include employment and income, housing and food, the environment and education. The division of wealth, power and resources at national, international and local levels creates these conditions (Commission on Social Determinants of Health 2008). The health effects of these social determinants are demonstrated between countries and between groups within a given society. It is clear that some people within our societies experience health outcomes much lower than population standards. People with mental health problems are more prone to experience chronic illnesses and to have shorter lifespans than the general population (Commission on Social Determinants of Health 2008, Laursen 2011, Lawrence et al 2013, Morgan et al 2014).

EMPLOYMENT AND INCOME

As a general rule, adults in full-time work spend more than half their waking hours in work-related activities (travelling to and from as well as direct work time). For many, a stable job in good working conditions is greater than just receiving a wage.

Employment also provides the revenue, choice and stability essential for good health and provides opportunities for social interaction and social inclusion as well as education and training. Employment is linked to positive mental health states, including improved self-esteem and self-efficacy as well as determination, whereas lack of employment erodes determination and identity (Allen et al 2014, Raeburn et al 2015).

Employment is influential in recovery from mental health problems and is well acknowledged by mental health consumers as the gold standard of recovery. According to the Mental Health Council of Australia 2006 survey (n = 284 participants), 81% of people surveyed with a mental illness were in some type of employment or were seeking to work (Mental Health Council of Australia 2007).

Conversely, unemployment is related to a range of deleterious health effects including depression (Hollander et al 2013, Jefferis et al 2011). Unemployment means limited income and this impacts on all other aspects of living, including housing and food security. Many countries make pensions and benefits available to ensure that people do not experience complete destitution. Yet, 'relative' poverty exists, which is the inequitable access to prosperity. It has been shown that people who have early life disadvantage will have disadvantage at all crucial points throughout their lives (McLachlan et al 2013). In addition, the consequences of disadvantage are inclined to accumulate and have intergenerational effects (Bask 2011, Corak 2013).

Given that nurses provide care to people from all walks of life, it is therefore imperative that they are attuned to poverty and disadvantage and assess for their effects as well as providing appropriate referral to other health professionals and agencies that work to address unemployment and poverty, including government agencies.

HOUSING AND FOOD

Housing and food security also influence health outcomes (Cook et al 2013, Doran et al 2014). Good housing should be affordable, safe, in good condition and not overcrowded. It provides the opportunity, via utilities and amenities, to enable sound physical and mental health. For a number of reasons, mostly related to limited access to resources and poor decision making, it is not uncommon for people with mental health issues to find themselves without adequate housing and they turn to health professionals for assistance. It is important for nurses to be aware of the options available for crisis accommodation and to refer consumers to housing agencies for longer-term solutions.

In developed countries people generally have regular healthy meals. However, there are people who cannot depend on adequate daily nutrition. Food uncertainty may be caused by inadequate income to afford enough good-quality food items, and inexpensive, poor-quality convenience foods, takeaways and fast food are appealing to people who have low incomes and who may not have had the education to make healthier choices (Mark et al 2012). In some countries, malnutrition is commonplace and this impacts on physical and mental health as well as social development (Lyles et al 2014, Tønnesen 2013).

Nurses across the globe must be aware of the influence of food on health, whether in

over or under supply. Nurses are in a strong position to educate people regarding adequate nutrition and this should include making the most of limited incomes and budgeting strategies to enable them to purchase and prepare healthy food.

THE ENVIRONMENT

The environment is one of the principal determinants of individual and community health (Swinburn et al 2011). Environmental determinants include naturally occurring elements such as the sun, or are manmade, such as emissions from vehicles (cars, trains, planes), industries or from cigarette smoke. Environmental hazards may be found at home, in the workplace and in the community. Poor health outcomes related to environmental determinants can include lead poisoning, occupationally induced respiratory problems and repetitive motion injury, among a multitude of other health problems.

Taking this into account, the use of the term *environmental health* refers to the absence of illness, or injury related to exposure to toxic agents and other environmental conditions that are potentially harmful to the health of the individual. While new chemical compounds continue to be introduced and their effects are unknown in many instances, many environmental hazards have well-documented adverse health effects on people, such as passive cigarette smoke, pesticides, chemicals released from new carpets and various synthetic materials.

Environmental hazards in workplace settings can be significant, and workplace injuries and fatalities are the most well-reported environmental influences on health. According to the Australian Bureau of Statistics (2018), 563,600 people (4.2% of the 13.4 million people who were employed during 2017–18) experienced at least one work-related injury or illness.

A number of toxins have also been found to directly impact mental health (Gibb & O'Leary 2014, Park & Zheng 2012). For example, mercury reduces the effect of some neurotransmitters and this reduction can partially explain feelings of lowered mood and lack of enthusiasm (Rice et al 2014). Lead also affects the whole body, and especially the central nervous system. High lead levels cause cognitive dysfunction, neurobehavioural disorders and neurological damage. In children with high lead levels, hyperactivity, anorexia, decreased play activity, low intelligence and poor school performance have been found (Grandjean & Landrigan 2014).

In summary, many environmental agents are potential health hazards (Jaishankar et al 2014, Wang & Wei 2018). All of these hazards are important and nurses and other healthcare providers should appreciate environmental health. Having an understanding of the impact of exposure to environmental toxins and resultant ill-health is important for nurses so that they may recognise these when encountered in practice (Bose-O'Reilly et al 2010). According to Watterson and colleagues (2005) few environmental health specialists exist in nursing and these are largely in infection control and occupational health nursing. They argue there is an urgent need for all nurses regardless of specialty or preparation to be aware of the impact of the environment on health. When nurses consistently take environmental risks into account when assessing a person's health status, they develop an approach to these risks that manages and minimises them

(Larsson & Butterfield 2002). It is essential for nurses to have a basic understanding of common environmental and occupational health hazards, the actions for prevention and, in particular, health promotion and how to ameliorate the effects of exposure. Nurses must also know what resources exist for specialist referral and support (Watterson et al 2005).

EDUCATION

According to Zajacova and Lawrence (2018) there is a well-documented association between education and health outcomes, which has been observed in many countries and over a long period of time. The differences between those with higher education and others are significant and research suggests that better education increases life expectancy (Kruger et al 2019, Olshansky et al 2012). Understanding how education influences health is important for policy makers. There are many reasons why education is related to better health outcomes, but it is most likely the result of health choices between education groups. Better educated people are less likely to engage in activities known to be high health risks: smoking, drinking, poor diet, gambling, lack of exercise, limited household safety, under-use of preventive medical care, and lack of care for hypertension and diabetes. Nevertheless, some of these health outcomes may also reflect disparities in access to health services.

An example of education is the Health Promoting Schools (HPS) initiative. New Zealand's approach to HPS commenced in 1991. HPS is an attitude to health promotion where entire school communities work together to tackle the health and wellbeing of students, staff and their community. Schools ensure health and wellbeing initiatives are embraced in preparation and evaluation activities, teaching methods, curriculum and assessments (Ministry of Health 2016a, b, c).

In 2010 the New Zealand Ministry of Health commissioned the development of a national strategic framework, which aims to support national consistency and evidence-based best practice, thereby making HPS more effective at improving student health and educational outcomes (Ministry of Health 2016a). Specifically, it enables the identification and privileging of health and wellbeing necessities to redress inequities within the school community and to meet such needs using a strengths-based approach. HPS connects various groups in a school community: child, whānau/family, education, health and social services, helping them collaborate to influence the community's health (Ministry of Health 2016b, c).

Nurses cannot change the education level of the people they serve but they can always provide up-to-date information to enable better decision making and stronger health choices. Nurses working in schools are well placed to achieve these goals.

Health promotion

Health promotion is a continuing field of development and according to the WHO, it is a process whereby people are enabled to have greater management over their health and ultimately improve it. It is more than merely changing individual behaviour but includes multiple social and environmental interventions

(www.who.int/topics/health_promotion/en/). Health promotion in mental health acknowledges 'that some of the major determinants of our mental health and wellbeing lie within the social and economic domains of our lives, and include social inclusion, having a valued social position, physical and psychological security, opportunity for self-determination and control over one's life and access to meaningful employment, education, income and housing' (Keleher & Armstrong 2005:1).

For mental health promotion and wellbeing to be a continued priority, a sound understanding of the current landscape is needed, including needs, context, policies, strategic plans and explanatory frameworks (Moodie & Jenkins 2005). In mental health services, the focus of care is generally on ameliorating the consequences of severe mental illnesses, such as impairment and disability, but this needs to be augmented by better health promoting strategies. Interventions that target severe mental illness and its negative consequences are different from interventions that promote health (Hutchinson et al 2006). Health promotion strategies can include implementing health-enhancing policies (e.g. employment opportunities), developing supportive environments (positive parenting initiatives), supporting community action (media campaigns), strengthening skills (resilience) and reorienting health services (screening programs) to enhance health and wellbeing (Kobau et al 2011). Many mental health promotion components could be readily embedded in existing programs in schools, health services and communities (Jané-Llopis & Barry 2005).

Keleher and Armstrong (2005) provide the following examples of mental health promotion activities/interventions to:

- increase social connectedness—school-based programs for mental health and wellbeing, workplace mental health promotion, volunteering, community arts programs, physical activity, and media campaigns;

- address violence and discrimination—community education campaigns, school-based and workplace bullying programs, discrimination prevention; and

- economic participation—adult literacy programs, childcare programs, youth employment programs, adult work programs, housing programs.

Severe mental illness often impacts social and economic status and these determinants can threaten health status (e.g. employment, income and housing). Areas with socioeconomic disadvantage are known to have increased rates of mental health problems compared with more advantaged areas (Rose & Thompson 2012) and limited financial means can also be a barrier to accessing mental healthcare. Targeting these determinants is a universal concern, and entails strategies to promote positive mental health and wellbeing of people at risk, not at risk and those who are experiencing or recovering from mental health disorders (Sturgeon 2006). Positive mental health in health promotion refers to how we can keep/what we can do to keep people healthy or healthier (Kalra et al 2012).

In New Zealand, an example of a national approach promoting mental health is the *Te Tāhuhu: Improving Mental Health* strategic plan (Ministry of Health 2016b). This outlined government strategies for mental health and addiction for the 10 years between 2005 and 2015. It provided the general direction for investment in mental health and addiction. The plan was informed by extensive public and health sector consultation and is based on an outcomes framework. It outlined 10 issues that needed to be addressed so that government objectives for mental health and addiction could be achieved. Specifically, objectives were for people to make informed decisions to promote their mental health and wellbeing and value diversity. It aimed to support and enable people with mental health and addiction problems to fully participate in society and in the everyday life of their communities and whānau through greater opportunities.

People with mental health and addiction problems should experience dependable services that work across boundaries to enable them to lead their own recovery. These services must provide choice, promote independence, be effective, efficient, responsive and timely (Ministry of Health 2016b).

Mental health promotion programs

As mentioned above, mental health promotion is a process that seeks to boost the capacity of individuals and communities to improve their mental health, with strategies seeking to foster individual resilience, while demonstrating respect for equity, social justice, culture and personal dignity (Jané-Llopis 2007). For strategies to be effective, broad sector involvement is needed such as health, industry, education, environment, justice, and social and community services (Jané-Llopis 2007). Working with and across diverse sectors is integral to successful mental health promotion given the determinants of health reach well beyond the scope of the health industry (Keleher & Armstrong 2005). Essential to this process is community participation and participatory methods, cooperation and trust, empowering, and working to address structural, policy and environmental issues, instead of only at individual levels (Barkway 2006, Jané-Llopis 2007).

The following are recommended to develop a mental health promotion program:

1. Base programs on the principles of efficacy and ensure processes are empowering, collaborative and participatory and stakeholders are included.

2. Clarify key goals and objectives and specify the key resources required for implementation.

3. Consider factors that will enhance efficacy and undertake a needs assessment.

4. Support capacity building and training across settings.

5. Develop a system of monitoring and evaluation of process, impact and outcomes.

6. Build on existing programs and integrate promotion components in established programs.

7. Consider feasibility, efficacy and sustainability.

(modified from Jané-Llopis & Barry 2005)

The WHO (2018) advocates for addressing the big picture issues and for mainstreaming mental health promotion and specific examples provided by WHO include:

- early childhood interventions (e.g. preschool psychosocial activities)
- support to children (e.g. skills building programs, child and youth development programs)
- socioeconomic empowerment of women (e.g. improving access to education)
- social support for elderly populations (e.g. befriending initiatives)
- programs and resources targeted at vulnerable groups, including minorities, Indigenous people, migrants and people affected by conflicts and disasters (e.g. psychosocial interventions after disasters)
- mental health promotional activities in schools (e.g. child-friendly schools)
- mental health interventions at work (e.g. stress prevention programs and team-building initiatives)
- housing policies (e.g. housing improvement)
- violence prevention programs (e.g. reducing availability of alcohol and drugs and access to arms)
- community development programs (e.g. integrated rural development)
- poverty reduction and social protection for the poor (e.g. a robust welfare program)

- anti-discrimination laws and campaigns
- promotion of the rights, opportunities and access to care of individuals with mental disorders.

(modified from WHO 2018)

Stigma, recovery and health promotion

The stigma surrounding mental illness is widespread and stigma is an identified barrier to seeking timely and relevant mental healthcare. Stigmatising attitudes are not uncommon towards people with mental health problems and people may experience stigmatising behaviours like being ignored or rejected by others, which have the potential to contribute to self-stigmatisation (Horsfall et al 2010). Combined with equity and access issues to mental healthcare, other issues may emerge or be exacerbated as a consequence (e.g. poverty or homelessness) (Cleary et al 2013).

To address the issue of stigma, national mental illness awareness campaigns have been implemented in an effort to reduce the stigma associated with mental illness (Corrigan et al 2012, Horsfall et al 2010). These types of health promoting campaigns seek to increase consciousness, provide education and challenge attitudes, but they cannot change discrimination in the areas of employment, housing and access to health and welfare services, which may or may not result from stigma (Horsfall et al 2010). Discrimination needs to be addressed on a number of levels so that stigma is not a barrier to recovery (Wahl 2012). Health professionals cannot be complacent about their role as more needs to be done.

Health promotion practices and philosophies are consistent with the recovery orientation movement (Hutchinson et al 2006). For example, having clinical symptoms does not preclude the experience of wellness, which can be experienced during recovery from mental illnesses. A recovery perspective is about personal recovery as opposed to clinical recovery. Identified principles of health promotion for people with psychiatric disabilities include:

- Health and access to healthcare are universal rights.
- Health promotion identifies the potential for health and wellness.
- Active participation in health promotion activities is best.
- Health education is the foundation of health promotion.
- Health promotion addresses the environments where people live, learn and work.
- Health promotion is all-inclusive and diverse in its use of many strategies

and pathways.

- Health promotion addresses each person's resource needs.

- Health promotion interventions must consider people's readiness for change.

(modified from Hutchinson et al 2006:247)

In mental health the recovery-oriented approach provides consumers with flexibility, choice and control, and because it is person-centred, it supports the consumer being an active participant in their healthcare. This is about supporting people's choices, goals and efforts for self-determination, not imposing goals or perceived needs on the consumer. Educational and practical support are necessary to strengthen the consumers' skills, self-efficacy beliefs, capabilities and sense of social connections and community participation (Svedberg 2011). The recovery approach recognises the influences of relationships, work, housing, education, finances, hope and the environment in which the person lives. Health promotion goals are consistent with the philosophies of nursing and recovery-oriented care, and entails enabling and empowering people to increase control to improve their sense of mental health and wellbeing.

Barriers to mental health promotion

Mental health promotion programs seek to identify and strengthen protective factors for health and wellness (Barkway 2006). Barriers to health promotion for people with psychiatric disability are numerous and many mental health treatment plans do not address primary healthcare, prevention or lifestyle and other health considerations as well as they could.

Identified challenges include conflicting philosophies, different staff education/training, organisational, management and time issues, limited funding and resources and fragmented health services (Murdaugh et al 2018, Verhaeghe et al 2013). Other factors which may impede the implementation of mental health promotion initiatives include stigma, confusion with terms such as health promotion/illness prevention, and the challenge of demonstrating outcomes (Barkway 2006).

There are also consumer issues. For example, consumers admitted to mental facilities may lack motivation to change lifestyle behaviours, such as smoking and substance abuse. Readiness to change is also an important consideration and the person may not deem the behaviour an issue or priority (Verhaeghe et al 2013). However, if nurses have a poor understanding of health promotion, this will impede and impact on the efficacy of nursing-related health promotion activities in their everyday care. In this regard, health promotion activities should be developed to decrease the risk and prevalence of comorbid conditions, in addition to recovery for people experiencing a mental illness (Hutchinson et al 2006).

Education and mental health promotion

Mental health promotion is an identified priority and integral to nursing practice, and nurses need to be able to identify potential health promoting opportunities, and plan these so that they are an everyday aspect of nursing practice (Verhaeghe et al 2011). This also requires a paradigm shift so that health is not viewed as the absence of disease, but instead mental health promotion is considered at a number of levels to ensure:

- those in leadership roles are included in education to promote change, ensuring a paradigm shift in the mainstreaming of the understanding and need for health promotion practices

- there is training in consultation and liaison roles for mental health nurses to ensure that secondary consultation, education and support to others is effective

- there are higher levels of mental health literacy within our communities to increase the understanding and acceptance of mental illness, mental health and wellbeing and that training such as Mental Health First Aid needs to continue to achieve this

- the public, health colleagues and others are educated about mental health roles.

(Woodhouse 2010:185)

To support this there is a need for knowledgeable nursing professionals and it is essential that education is provided during undergraduate, postgraduate and continuing professional education about stigma. It is recommended that the mainstream approach to teaching mental health, clinical work and research should be changed to a more person-centred orientation that supports recovery (Horsfall et al 2010) and mental health promotion. The PROMISE project (Greacen et al 2012) identified 10 quality criteria for training social and healthcare professionals in mental health promotion, which include:

- espousing the principles of positive mental health

- enabling communities

- adopting an interdisciplinary and inter-sectoral approach

- including people with lived experience of mental health problems

- advocating
- referring to the evidence
- contextualising interventions
- assessing risks
- using the media
- evaluating training, implementation processes and outcomes.

(modified from Greacen et al 2012)

Workplace policy development is also important to advance mental health and wellbeing. In order for mental health promotion initiatives to actually be health promoting, not just targeting people *at risk* of mental illness, activities are required that work towards strengthening *protective* factors for whole populations, and these need to be multi-faceted, which includes the workplace (Barkway 2006). Actions and strategies should develop an environment and workplace setting that supports positive mental health and the maintenance of healthy lifestyles (Shattell & Apostolopoulos 2010).

The role of media in mental health promotion

Media is a powerful influence on the way people think and behave. Media includes mass outlets, such as television and newspapers, or social media and digital media, such as the internet. Media can be useful for presenting health information to advocate for change, support other health promotion work, to market available resources, maintain health behaviours or to keep health matters in people's minds (Wakefield et al 2010). The internet and social media are a virtual setting for promoting mental health and wellbeing as communication tools for information and guidance and a source of support, facilitating connection with others. This virtual environment has a number of positive potential effects:

- the formation and continuation of relationships (family, schools, workplace, community, services)
- the provision of therapeutic interventions
- the improved understanding of mental health and its significance for general health and welfare
- the encouragement of communities and individuals to determine their own actions to promote mental health and wellbeing

- the engagement with mental health literacy for individuals, communities and organisations
- the funding of policies that promote mental health.

(Barry 2013)

Mental health promotion occurs where people live. Using technologies enhances access to resources and supportive opportunities to improve determinants of health. They also contribute to the development of social skills including coping, efficacy and esteem and problem solving (Clarke et al 2013).

Technologies have the ability to create greater public appreciation of the importance of positive mental health as a foundation of daily life. Using technologies provides many opportunities for mental health promotion. Acknowledging the importance of the digital world in the lives of young people entails a change from universal top-down strategies of informing the community to a more person-centred approach where formal communication engages in social dialogue and builds trust with the public: a tailored approach to communication. Technologies can also expand the focus beyond individual interventions: strengthening social capital through the creation and maintenance of social networks, strengthening active citizenship, social wellbeing and civil society, creating supportive environments for mental health (mental health promoting organisations), being a tool for advocacy and mobilising change with wider public and cross-sectoral engagement concerning the importance of mental wellbeing and advocating for investment in mental health promotion and prevention and critical digital literacy skills (Clarke et al 2013).

Technologies can also enhance mental health literacy (Barry 2013). Health literacy involves knowledge, drive and aptitudes to appreciate, evaluate and use health information to make decisions regarding healthcare, illness prevention and health promotion to sustain or enhance quality of life (Australian Commission on Quality and Safety in Health Care 2015).

The role of the nurse

According to the WHO, 'nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people' (WHO 2016:1).

Nurses currently make up more than 50% of the paid health workforce. In numbers alone, they have the potential for great impact in promoting mental health. The International Council of Nurses (ICN) (https://www.icn/) identifies that nurses are the foremost group in health to provide health promotion at all levels through their links with individuals, families, communities and their associated liaison with health services. While working individually, with other members of the health profession, or across health sectors, nurses investigate innovative and improved ways of maintaining or improving health and preventing illness and incapacity. Nurses can advance equity

and access to healthcare and enhance the quality of health outcomes.

Nurses are therefore essential to universal approaches to mental health promotion and mental illness prevention, as well as the recovery of people living with mental health problems and support of their families and communities. In addition, nurses are vital in diminishing the stigma of mental illness. The ICN considers that best practice in mental health services will only be realised through an organised, inter-sectoral, community-based approach. The ICN encourages policy makers to focus on the promotion of mental health, and prevention of mental illness (see International Council of Nurses information in the Online resources section at the end of this chapter).

Nurses spend a lot of time with people, perfectly placing them to influence. Mental health promotion relies on the connection and communication between nurses and others. Developing the knowledge and skills that foster people's sense of agency and resilience will facilitate this. Positive mental health is internalised and is enriched when people are helped to recognise their own strengths (Ruddick 2008) and their ability to cope with adversity is strengthened (Barkway 2006).

Educating nurses in the application of solution-focused communication in their interactions with clients supports these goals. Solution-focused communication skills can be taught and incorporated into nurses' interactions emphasising what people can achieve, rather than their limitations (Ruddick 2013). Solution-focused techniques can help people focus on their goals and strengths and this can motivate them to make constructive decisions and take constructive actions (O'Connell 2005). According to Ruddick (2008) solution-focused communication is fairly easy to learn and practise as well as being inexpensive and generates the belief that positive outcomes will ensue. Finally, promoting mental health requires nurses to maintain currency in practice, participate in continuing professional development, recognise opportunities for health promotion and, importantly, collaborate with communities and other key stakeholders.

CONCLUSION

Mental, physical and social health are closely linked. There is clear evidence that the physical health of people with a serious mental illness is cause for concern and this can affect quality of life and life expectancy. Twenty per cent of Australian adults are likely to experience a mental disorder in any 12-month period. Mental health promotion is therefore pivotal to the health of the community. Importantly, the nursing profession is well placed to develop and support mental health promotion within a recovery-based approach. To foster community development there needs to be a focus on population health, which shifts the emphasis from the individual to the group. Population health incorporates all the known influences on the health of different groups: the social determinants of health.

The aim of mental health promotion is to increase the ability of people both individually and collectively to be in control of their lives and improve their mental health. Approaches are intended to promote helpful environments and personal resilience, amidst fairness, respect and maintenance of personal self-esteem. Nurses have a pivotal role to play in supporting mental health by promoting opportunities for potential health promotion activities. Strategies may include using multi-media to present health material or to encourage change. Actions focusing on the social and economic determinants of mental health and wellbeing that support participation, collaboration and the empowerment of individuals and communities are important. These collaborative activities share common values, and are consistent, with recovery-oriented frameworks for care.

Online resources

This chapter has introduced you to mental health promotion. To continue your development in this area, please refer to the resources available at the following websites.

Australian Commission on Quality and Safety in Health Care (2015): http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/

Australian Government, Department of Health, Mental Health Promotion: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-pol08-toc~mental-pubs-n-pol08-2~mental-pubs-n-pol08-2-2

Australian Government, Department of Health, Mental Health: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Mental%20Health%21

International Council of Nurses: https://www.icn.ch/nursing-policy/position-statements

A national framework for recovery-oriented mental health services—policy and theory: https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

A national framework for recovery-oriented mental health services—guide for practitioners and providers: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde

The Victorian Government: http://www.health.vic.gov.au/mentalhealthpromotion/resources.htm

WHO 2018 Mental health: strengthening our response: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

REFLECTIVE QUESTIONS

Take some time now to consider what you have read in this chapter and write your answers to the following questions.

1. What prevention strategies can be taken for mental disorders and to reduce the mortality, morbidity and disability for people with mental disorders?
2. For health services to provide comprehensive, integrated and responsive recovery-oriented mental healthcare, identify the strategies that need to be undertaken to address this to increase consumer partnerships and use of the recovery ideology.
3. Thinking about the social determinants of health, how can nurses help to achieve improved employment, education, housing and physical health for people living with mental disorders?
4. In your community or work setting, identify the activities that reflect organisations' and governments' aims to achieve health promotion outcomes.
5. What would an anti-stigma campaign look like?

Online resources

This chapter has introduced you to mental health promotion. To continue your development in this area, please refer to the resources available at the following websites.

Australian Commission on Quality and Safety in Health Care. http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/, 2015

Australian Government, Department of Health, Mental Health Promotion. https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-pol08-toc~mental-pubs-n-pol08-2~mental-pubs-n-pol08-2-2

Australian Government, Department of Health, Mental Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/Mental%20Health%21

International Council of Nurses. https://www.icn.ch/nursing-policy/position-statements

A national framework for recovery-oriented mental health services—policy and theory. https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra.

A national framework for recovery-oriented mental health services—guide for practitioners and providers. http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde.

The Victorian Government. http://www.health.vic.gov.au/mentalhealthpromotion/resources.htm

WHO. Mental health: strengthening our response. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response, 2018.

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CHAPTER 18: THE CHALLENGES AND REWARDS OF RURAL AND REMOTE NURSING

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KEY WORDS

communities; health; healthcare; Indigenous; nursing; remote; rural

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- identify the nature of rural communities and the major factors that influence their health status;
- outline some of the challenges of providing healthcare in rural and remote locations;
- describe the characteristics of rural and remote nursing and the challenges and rewards of the role;
- identify the continuing challenge for nursing in addressing the health needs of rural and remote communities.

INTRODUCTION

Rural nursing is a dynamic and rewarding area of nursing practice that offers many unique professional experiences. If you have had little personal experience of living in the country, understanding how rurality shapes nursing practice and the health of these communities is a challenging task. This chapter is focused upon the health of rural and remote communities and the multifaceted nature of living in these locations. In this context, the scope of practice, challenges and rewards of rural nursing are outlined.

Rural nursing

The health of rural and remote communities, and the challenges of providing healthcare in locations that are often long distances from major urban centres, has gained much government attention (Wakerman & Humphreys 2019). Though rural and remote healthcare has increasingly become the focus of policy makers and governments, with attention often upon recruiting and retaining general practitioners (GPs) (Australian Government Department of Health 2018), nurses have a long tradition of providing care in rural and remote locations. Nurses, midwives and Aboriginal and Torres Strait Islander Health Workers represent by far the largest group of health professionals in the rural sector (Department of Health 2017). In many rural and remote communities, nurses are recognised as the backbone of healthcare and are 'specialist generalists' who provide for the breadth of healthcare needs of their community, ranging from primary healthcare, mental health, palliation, chronic and aged care to emergency and crisis intervention (CRANAPlus 2017).

Distance from urban centres and population sparsity are frequently used to define the concept of rurality. These are useful concepts to initially understand the concept of remoteness; however, the concept of rurality is not one-dimensional; instead, location, history, culture, economic policy, place and identity feature strongly in what it means to be rural or live in a rural or remote location. For nurses working and living in these locations, the nature of their practice is strongly influenced by all of these factors, making rural nursing one of the more challenging and rewarding fields of nursing.

Introducing rural and remote populations

Approximately one-third of the Australian population live outside of major urban settings and, of these, 12% reside in outer regional and remote locations. Likewise, close to 14% of New Zealanders live in locations classified as remote (Australian Institute of Health and Welfare (AIHW) 2018). Reflecting the distance from urban centres, Australian settings are described as either being inner or outer regional, remote or very remote areas (AIHW 2019). Similarly, in New Zealand, settings are classified into rural areas of either high, moderate or low urban influences or reliance, or highly rural/remote areas that have relative independence from employment from urban centres (Statistics New Zealand 2012).

Despite the distance from urban centres, communities and people classified as rural or remote are not a homogeneous group (AIHW 2019). Traditionally, rural and remote communities have been portrayed through stereotypical images of living in the sticks, farming the land and being somehow backward or inferior (Malatzky & Bourke 2018). In stark contrast to these assumptions, country people do not necessarily live on a farm and they are not inevitably rustic; instead, they live in many different places and are characterised by great diversity and innovation. Rural and remote communities can include farming, coastal and rainforest regions, communal living and tourist islands or mining towns that are characterised by their unique cultural and philosophical beliefs. This diversity needs to be reflected in the types of healthcare services that communities can access locally (Wakerman & Humphreys 2019). Importantly, people living outside of urban settings often have strong cultural, spiritual or generational ties that can exist to the land, traditions and the people, which can shape the sense of personal and community identity. Indigenous peoples' identity is inextricably linked to community, person, land, spirituality and place, creating complex relational bonds and reciprocal obligations (Jones et al 2018).

As nurses, when reflecting upon what it means to live in or come from the country, it is important to move beyond defining rural and urban in simple geographic, consumerist or material terms. Instead, it is important to give attention to understanding the subjective, deep-rooted and shared social understanding of association and identification that shape rural character and culture. Understanding the health of rural and remote people requires that one consider the relationship between people, place and identity. In rural and Indigenous peoples' identity, the sense of connection to place is so strong that for many, being removed or relocated away from their place of country for healthcare can and has caused considerable distress (Salmon et al 2018).

REFLECTION

Think of a rural or remote location—describe the characteristics of the people living in this community. What has shaped your impression?

Or, if you do not have experience or knowledge of a rural or remote location, think of a film or television depiction of a rural community. How were rural people characterised? What do you think has shaped these depictions?

The tyranny of distance and population sparsity

In rural and remote contexts, the cost of delivering services is higher per capita when compared with the city (Hamilton et al 2018). As a result, resources are often spread sparsely across large areas. On average, rural and remote people are disadvantaged in their access to goods and services, and may have greater exposure to risk factors that cause ill-health compared with their urban counterparts (AIHW 2019; Hamilton et al 2018). For these communities, the tyranny of distance is also compounded by population numbers, which in many instances may be too small to generate sufficient demand to sustain viable services, which can set in place a cycle of service decline and further population drift (Brabyn 2017). Shrinking populations lead to a fall in demand, which in turn leads to decreased employment and a continued drain on the population as people leave the community, particularly younger adults who may leave in search of work (Australian Bureau of Statistics (ABS) 2015).

Recent decades have seen significant demographic and economic change in rural and remote communities. Many communities have experienced the simultaneous redesign or withdrawal of services, population decline, growing unemployment and a deterioration in their living conditions (Commonwealth of Australia 2012). Economic and resource-driven models of service provision and urban-centric approaches to education, transport and health policy have impacted the resilience and population growth in rural and remote communities (Bec et al 2018). Cost-effectiveness and the centralisation of services have seen the redesign or loss of healthcare facilities, schools and other essential services such as banks. This change has had a profound effect on the social circumstances of people living in these communities and is said to have exacerbated economic decline and population drift (Hettihewa & Wright 2018). In contrast to this picture of decline, some rural and remote communities have experienced economic and population growth. The movement of retirees to regional and rural coastal towns has been a driver of change in coastal fringes and the migration of younger families has occurred in some larger rural centres (Elin et al 2016). These shifts in population mean that, in some communities, the distinction between rural and urban identity is no longer as clear-cut as it may have been in the past, with once rural country towns becoming large regional centres. The movement of populations in this way also amplifies the imbalance in healthcare provision, with population growth moving ahead of the capacity to provide services.

The health of rural and remote communities

People living in rural and remote communities face many challenges; in the main they experience more health disadvantage, are less healthy, experience greater illness and mortality than their city counterparts and have lower rates of GP consultation and generally higher rates of admission to hospital (AIHW 2019). The deeply embedded economic and social disparity experienced in rural and remote communities equates to lower incomes, fewer healthcare and educational opportunities and higher rates of

illness and mortality (AIHW 2019). For conditions such as cancer, there is evidence to suggest urban–rural differences in outcomes, with people living in outer regional and rural locations having an 8–15% higher risk of death from colorectal cancer (Afshar et al 2019). Time to diagnosis and treatment is significantly longer in people living in rural and more remote communities for some cancers (Bergin et al 2018). Refer to Box 18.1 for a summary of current information related to the state of health in rural and remote populations.

BOX 18.1 The state of health in rural and remote populations

- People residing in rural and remote areas are 5.4 times more likely to experience death due to transport accidents compared with people residing in regional and city areas (AIHW 2018).

- As remoteness increases, so does the incidence of cigarette smoking, overweight and obesity, low levels of exercise, exceeding lifetime alcohol risk (AIHW 2018).

- Residents of remote areas in New Zealand and Australia have fewer educational qualifications than the national average and have much lower rates of expected university completion (Sullivan et al 2018).

- In Australia, approximately 20% of Indigenous peoples live in remote or very remote areas, and on the whole their life expectancy is approximately 15 years lower compared with that of non-Indigenous people (ABS Australian Government Dept of Ageing 2018).

- Māori-Indigenous New Zealanders residing in rural areas have a lower life expectancy compared with their non-Indigenous counterparts (Crampton & Baxter 2018).

For people in rural and remote regions, the limited access to healthcare services can be exacerbated by widely held attitudes to health, illness and help seeking. In reviewing the literature, Carolan and colleagues (2018) note that rural people are more likely to delay seeking healthcare, are often more concerned about the stigma of illness, and are focused on practical problem solving in preference to help seeking. A recent systematic review of qualitative studies noted that stoicism, stigma and distrust were attitudinal barriers to mental health help seeking among people living in rural areas (Cheesmond et al 2019). An additional complexity rural people may face in disclosing their health concerns is that the professional may reside in their community, or alternatively, when seeking care from distant services they hold concern that cultural or behavioural differences may result in them being misunderstood. Individuals residing in rural areas,

in particular men, are more likely to avoid seeking healthcare, with help seeking for mental health lower than for physical health concerns (Fennel et al 2018). A concerning outcome associated with these help-seeking characteristics is the elevated rates of suicide in rural and remote populations, particularly among males (Crnek-Georgeson et al 2017).

Throughout Australia and New Zealand, rural and remote communities are often recognised to be Indigenous communities (inclusive of Aboriginal, Torres Strait Islanders and Māori) with their health being an important part of the fabric of rural life. The poorer health status of Indigenous people contributes to the higher rates of morbidity and mortality in rural and remote communities (AIHW 2018). Indigenous people residing in rural areas have a lower life expectancy, an increased rate of low birthweight and infant mortality, higher interpersonal violence and an increased risk of suicide (AIHW 2018). A retrospective study reported the fatality rate for Aboriginal children admitted to the Sydney Children's Hospital was double that of non-Aboriginal children, with Aboriginal children under two years and from remote and regional communities at highest risk of excess mortality (Singer et al 2019). Importantly, most Indigenous communities have a younger population profile, and among young people (aged 10–24 years) in these communities there is an increased burden of chronic health problems such as mental illness, type 2 diabetes and ischemic heart disease (Azzopardi et al 2018). There is also an increased risk of developmental vulnerability, stemming from long waiting times for assessment, diagnosis and treatment, and difficulty accessing paediatric health services (Cumming 2019).

Ageing is another factor affecting rural and remote communities, with lack of access to local appropriate services being particularly problematic. By 2021, it is anticipated that the growth in the older population in rural areas will be twice that of metropolitan areas (Hancock et al 2019). The National Rural Health Alliance (NRHA) has estimated that the funding deficit for aged care in rural areas is in excess of $500 million per annum (NRHA 2016). Little is known about how the experience of growing older may be different in urban and rural areas. For many older people in rural and remote locations, needing help at home can mean relocating away from family and friends either temporarily or permanently. Given the strong association with community and sense of place among rural people, moving away to supportive accommodation is particularly problematic (Gardiner et al 2018). In some communities the elderly may be relocated to residential aged care facilities up to 12 hours' distance from their rural home community. Drawing attention to this dislocation, Anderson and colleagues conducted interviews with rural older people noting that kin and non-kin networks were important factors in the ability for older people to remain in their community (Anderson et al 2018). Having to move out of community for residential care, places considerable burden on families and carers who must travel to provide support and maintain relationships.

The challenge of providing health services in rural and remote locations

When regional, rural and remote locations are compared with urban centres, they often have lower levels of access to health services and the profile of the health workforce varies significantly. In general, there is a misdistribution of the health workforce between urban centres and rural and remote communities and attracting experienced healthcare professionals to these locations is a constant challenge (Cosgrave et al 2019, Nixon & Lawrenson 2019). Both Australia and New Zealand have relied extensively on overseas trained healthcare professionals to fill this void (Cosgrave et al 2019), with financial schemes and training programs continually being developed to attract healthcare professionals, including nurses, to staff regional and remote healthcare positions. Despite more than a doubling in the number of Australian-trained healthcare professionals since the 1990s, locally trained graduates are less likely to take up employment in rural communities compared with graduates from previous decades (O' Sullivan et al 2019). In response to the continuing challenge of recruitment in rural and remote communities, a number of specific models of health service have been developed—these include: Indigenous health services, which are often community-controlled organisations; multi-purpose services that provide integrated services such as aged care, medical or community services; the Royal Flying Doctor Service, which provides emergency and primary care outreach services; outreach medical and allied health services and on-call primary care services staffed by GPs and nurses. Other strategies to improve access to specialist and primary care services in outlying communities include fly-in fly-out (FIFO) services. However, a disadvantage of services that rely on outreach from urban centres is the under-development and lack of resourcing for local healthcare systems (Hussain et al 2015).

The presence of a hospital remains an important factor in the provision of health services in rural or urban communities and the presence of a hospital is an important factor in the decision for health professionals to live and work in a community (Nancarrow et al 2015). In Australia, New Zealand and internationally, recent decades have seen the downgrading and closure of many rural hospitals and an increase towards care and services provided in the home, and primary services through e-health and/or major urban centres (Australian Government Department of Health 2018, Australian Medical Association 2016). Across Australia over the past 20 years, 368 maternity units have closed in rural and remote areas (Prussing et al 2018). These rural closures occurred largely on the basis of being unable to provide 24-hour on-site surgical and anaesthetic services to be considered safe. Concern has been raised that these types of reforms provide particular challenges for the equitable provision of services to people living in rural and remote locations, and evidence is emerging challenging earlier assumptions about safety that underpinned rural maternity service closures (Kruske et al 2015). In response, midwifery-led services are emerging as a strategy to maintain rural and remote birthing services (Prussing et al 2018).

The need to travel a considerable distance for healthcare means that vulnerable people, often from the most socioeconomically disadvantaged areas of the country, have to find the financial and support resources to cope with this dislocation (Eversole 2016). The development of e-health initiatives, such as remote liaison nurses who link and support patients from remote areas to metropolitan hospitals, are an important

initiative bridging the disadvantage caused by distance from treatment facilities. As IT and communication technology has evolved, technologies such as tele-radiology, e-health, telehealth and video conferencing are being extensively employed in rural and regional communities (Leblanc 2019). A recent systematic review noted telehealth was largely provided by nurses with limited local medical support. These services report improved diagnosis and patient management, a reduction in unnecessary transfers and low levels of discharge against advice (du Toit et al 2019). Telehealth services now deliver expert consultation in areas such as mental health, paediatrics, oncology, gerontology, palliative care, cancer care, the treatment of hepatitis C and the management of diabetes, heart failure and wounds, to rural and remote communities. Telehealth ranges from computer-based support and web-based video consultation with specialist clinicians to store-and-forward diagnostics for remote interpretation. These services operate in community nursing services, hospitals, general practices and residential aged care facilities and report a high level of acceptability by patients (Orlando et al 2019). The increased use of e-health is an important strategy to address urban–rural health disparities and reduce the likelihood of patients needing to relocate for treatment. For outback communities, the challenge remains to improve access to supportive technology. Access to mobile phone coverage is limited in more isolated areas, limiting download allowances and speed, which does not support video conferencing or video consultation (Bauerly et al 2019). As rapid care for complex conditions becomes a growing reality in the city, the challenge remains how to provide similar care in remote parts of the country (Leeder 2016).

The challenge of providing health services in rural and remote communities not only shapes the services available, it has a major impact on the practice of health professionals. Imagine a serious accident over 500 km from a major health facility and 150 km to the closest town with a small hospital, and it is possible to begin to understand the challenge of providing healthcare in rural and remote contexts. In many settings, nurses will be required to respond to such an accident and, in the more isolated locations, may have little immediate support or back-up.

REFLECTION

Identify a rural town and conduct an internet search to identify the range of health services available to residents.

Do you think that the health services provided are equitable compared to those for residents in a major urban city?

Imagine you are a nurse in this community. Where might you work, what other services would be available to support you in your role and what types of telehealth services might outreach to this community?

The nature of rural and remote nursing

Rural and remote nursing is dynamic in nature and offers immense opportunity for professional and personal development. Nurses working in these locations describe their work as more diverse than their urban counterparts do, and the varied nature of this work provides opportunities and challenges unique from other nursing experiences (Onnis 2019, S Smith et al 2019). Rural and remote nurses are often somewhat embedded within the community in which they work. They establish strong relationships with community members and are frequently perceived as being a part of the community to whom they provide care (Kulig et al 2018) and for whom they care throughout the lifespan. The experience of nursing in a rural or remote context is often characterised by the development of deep and effective relationships in the communities that nurses serve with a sense of connection to the place and the community in which care is provided (Oosterbroek et al 2019).

In their dual role of nurse and community member, rural and remote nurses will often personally know or have knowledge about most people in their community (Kulig et al 2018). This lack of anonymity, entwinement of personal and private lives and the high level of visibility create particular challenges for nursing practice. When a nurse in an urban hospital provides care, few but the immediate family of the patient know the details of the care provided. In contrast, the actions of rural nurses are more visible and known to the community. This high level of visibility can be a difficult work–life challenge for nurses who take up employment in rural and remote communities and contributes to higher levels of safety risk. Maintaining privacy and confidentiality in this context require that nurses establish clear boundaries between their private and work life and strategies to ensure patient confidentiality (Lenthall et al 2018).

Scope of practice

Rural and remote nursing is characterised by a high degree of responsibility and autonomy, considerable flexibility and a requirement for extended or advanced skills (McKenna 2019). As broad generalists, rural and remote nurses' practice includes prevention, primary care, rehabilitation and acute interventions, and requires both clinical and cultural skills (Dunbar et al 2019). In more geographically isolated areas nurses are likely to be the principal clinician on site, working at a distance from the multidisciplinary team. These nurses can experience a compression of the complexity of their role as they fulfil advanced roles, and also take on additional unplanned expectations (Kulig et al 2018).

In both Australia and New Zealand, the scope of practice of rural and remote nurses has been described as extended, advanced and expanded (Bell et al 2018, Lowe & Plummer 2019). Furthermore, the scope of practice of nurses working in these settings varies according to the needs of the population and the range of other services available. Though scope of practice in these regions varies, rural and remote nursing encompasses both primary healthcare approaches and the provision of general nursing

care, including provision of comprehensive assessment, diagnosis and case management, interventions such as suturing, plastering, prescribing and/or supplying medication, transferring patients to metropolitan areas, as well as involvement in health education and screening, public health initiatives and health promotion (Burrows et al 2019, T Smith et al 2019).

In outer regional and remote locations, additional multidisciplinary services are provided by outreach services and various forms of telecommunication support consultation. This means that nurses in these settings must establish and maintain effective working relationships with other team members who are often at a considerable distance (Crowther et al 2019, Kosteniuk et al 2019). Furthermore, nurses and Indigenous health workers' areas are often the mainstay of health services in remote areas (CRANAplus 2016). This working relationship provides the 'cultural mentorship' that nurses require working in such a demanding environment, and helps ensure the care they provide is culturally appropriate (Liaw et al 2019).

Extended, advanced and solo nursing roles

As remoteness increases, there are a decreasing number of healthcare professionals available within communities and the scope of practice of nurses becomes more extended or advanced. For many nurses in rural and remote locations their practice extends across the scope of registered nurse practice to include the full spectrum of care, from the provision of primary healthcare to frontline emergency care; they can be considered as the 'jack of all trades' (Burrows et al 2019, S Smith et al 2019). Working as a nurse in remote locations requires not only experience, but also extensive knowledge, specialised skills and the ability to adapt to changing health scenarios (T Smith et al 2019). For example, imagine providing diabetic education in the morning and by the afternoon providing frontline critical care to a patient who has been involved in a motor vehicle accident.

Providing on-call services is a feature of outer regional and remote locations and nurses work in partnership with doctors or, in instances where there is no doctor available, nurses are the mainstay of healthcare and on-call coverage for the local community. In New Zealand, the significant increase in primary healthcare nursing workforce, post-graduate qualifications and nursing autonomy in these roles (Daly et al 2018) attests to the breadth of knowledge and care that these nurses provide to rural and remote communities.

While the majority of nurses working in regional communities work within small multidisciplinary teams, nurses working in very remote areas often do so on their own. In a number of remote Indigenous communities, fly-in mine sites or small isolated towns, solo-nurse clinics operate to provide the only form of on-site healthcare. These nurses live and work in physically difficult circumstances, are required to undertake high levels of on-call work, have heavy workload demands and report a high level of safety risk and personal violence (Lenthall et al 2018, Wressell et al 2018). Nurses working in these settings are often unable to take leave and are on 24-hour call for long periods of time (Lenthall et al 2018). High staff turnover resulting from these pressures increases the workload for remaining nurses and is associated with poorer health

outcomes for Aboriginal peoples living in remote communities (Zhao et al 2019). These issues have been of longstanding concern to remote area nurses, with a growing consensus that solo-nurse services should be abandoned in favour of teams of nurses with suitable qualifications and experience to undertake this role (Lenthall et al 2018).

Even though university courses and government initiatives have been introduced to support the rural nursing workforce, and some nurses working in remote communities have expanded their knowledge and undertaken postgraduate qualifications, the literature suggests that many are still ill-equipped and poorly prepared for the demands of extended and advanced practice roles (Humphreys et al 2018). Literature also suggests that there is a decline in rural and remote nurses undertaking specialised skills, such as those associated with women and child healthcare (Gwynne & Lincoln 2017), which is an essential component of primary healthcare in rural communities.

To meet the demands of underserviced healthcare needs in the community, remote nurses fulfil advanced practice roles far wider than that of the nurse practitioner, often with minimal formal preparation for the role and outside of the legislated boundaries of registered nurse practice (MacLeod et al 2019). A continued criticism of Australian rural health policy has been an almost exclusive policy focus on medical workforce supply issues. While it is important to acknowledge the importance of doctors, any solution to the critical problems faced by rural and remote communities must also address nursing workforce issues.

REFLECTION

What do you think the differences would be in working in a remote community such as Coober Pedy in Australia or the Gisborne region of New Zealand as either a registered nurse or an undergraduate nurse compared with working in a large metropolitan referral hospital in a capital city?

Have you or would you consider undertaking a clinical placement in a remote community? Why or why not?

The challenge of sustaining the rural and remote workforce

Although rural and remote area nurses have greater autonomy and can work to their full scope of practice, a downside of the role is that this group of nurses are more likely to experience high levels of occupational stress. The demands of working in rural and remote settings is said to be compounded by workload and scope of practice, poor management, and violence and safety concerns (Lenthall et al 2018). In the face of these challenges, rural and remote area nurses can experience considerable role stress (Lenthall et al 2018) and exhaustion (Dunbar et al 2019), with additional pressures stemming from unrealistic expectations of communities and health services that cannot be met (Lenthall et al 2018).

Highlighting the difficulties and work stress experienced by nurses working in remote areas, in one study, nearly all reported that working in a remote area was emotionally more demanding than most other roles they had undertaken. Elements of the work that increased emotional demands included the poor health of Aboriginal peoples, poor orientation and the frequency of emergencies (Lenthall et al 2018). Although rural and remote nursing is characterised by many challenges that increase the likelihood of experiencing psychological distress, these frustrations are, in the most part, related to management and resources rather than to the communities or individuals. Interventions such as reducing the number of single-nurse clinics, introducing on-call phone systems and increasing the use of drivers for call-outs after hours have been implemented to address stress and burnout (Lenthall et al 2018).

Recruiting and retaining a health workforce is a significant issue across Australia and New Zealand. In response, educational providers have developed a range of undergraduate clinical placement initiatives to expose students to practices in rural and remote settings. Research suggests that these placements provide students with preparation and support, a rural or remote health experience, and exposure to rural lifestyles and socialisation (Smith et al 2018). These programs are based on the premise that rural placement programs provide for unique clinical experiences and influence more positive views about future work in such areas (Fatima et al 2018).

However, living and studying in rural communities can create particular challenges for students and preceptors. Preceptors may struggle to make themselves available to students due to work demands and the limited number of staff available at any one time (Bowen et al 2019), while students report that a sense of isolation can increase stress (Isaac et al 2019).

In rural areas, new graduates have the added challenge of transitioning to work roles that demand a broader knowledge base and range of generalist skills. Lea and Cruickshank (2015) highlight the importance of providing additional support for graduates to ensure they successfully transition to practice in the rural workforce. These types of transition program provide increased opportunities for learning, as well as additional guidance as graduates adapt to the unique aspects of the rural nurse's role

and responsibilities (Lea & Cruickshank 2015). A number of initiatives are also in place to attract graduates to rural areas. However, these are largely, but not exclusively, targeted towards medical graduates. These initiatives include salary incentives to work in areas of greatest need, bonded scholarships and a range of non-financial incentives for graduates.

STORY

Brianna's story: a telehealth solution

Charleville is located in Queensland and is an 8-hour drive southwest of Brisbane. 'Sarah' lives in Cunnamulla and travelled 200 km to the Charleville hospital to give birth to her daughter, Brianna.

At the hospital, Brianna's newborn hearing screening test identified that she needed further follow-up testing. This follow-up testing when Brianna is six months old is available through specially trained child audiologists operating from a Hearing Clinic in Brisbane.

Typically, babies such as Brianna would need to travel to the clinic in Brisbane for further testing. Brianna is the fourth child in the family and, for her parents, travelling to Brisbane for this testing is not only expensive, the family would need to organise someone to stay at Cunnamulla to care for Brianna's siblings.

Charleville Hospital employs a telehealth nurse, and the hospital provided more than 200 telehealth consultations in the previous year. To enable Brianna to undergo the further audiology testing that she needed without travelling to Brisbane, the telehealth nurse at Charleville organised for the testing equipment to be couriered to the hospital. This enabled staff at Charleville to perform the testing with the consultation linked via telehealth to the child audiologist in Brisbane. This provided real-time remote assessment of Brianna's hearing.

Detection and early treatment of hearing loss in infancy is vital to ensure early normal speech and language development.

The circumstances described in Brianna's story demonstrate how technology is transforming the provision of healthcare in rural and remote locations. Children living in remote areas are likely to experience limited or no access to paediatric allied health services, such as speech therapy. This increases the risk of developmental delay, and children in very remote areas are twice as likely as those living in major cities to be developmentally vulnerable (Royal Far West 2017). Thus, the risks of delayed or missed diagnosis and limited access to therapy are greater for infants such as Brianna. Initiatives such as telehealth have the potential to significantly address barriers to healthcare experienced by rural and remote communities. Nurses are at the forefront of leading many of the telehealth initiatives in these communities. These changes will impact on how nurses undertake assessment and create additional challenges with regard to consent, patient education, confidentiality and record keeping.

CONCLUSION

Nursing has a long-established tradition of providing healthcare in rural and remote locations, often in the face of great adversity. The determinants of health for people living in rural and remote locations are poorer than for their urban counterparts. This disadvantage arises from a complex interplay of geographic, economic, social and policy factors. This disadvantage impacts not only on the people living in these communities and seeking healthcare, but also on the healthcare workers who support these communities. In recognising these challenges, educational programs and government support and incentives are continually being implemented to foster growth, safety and improved working conditions among rural and remote nurses and to facilitate optimal care for people residing in rural and remote communities. Despite these challenges, rural and remote nursing is a highly rewarding career that offers unique and rich experiences that can be both professionally and personally fulfilling.

Reflective questions

1. Critically reflect upon Brianna's situation and consider the possible impact of missed follow-ups for rural and remote infants and children. How is telehealth reducing these risks?
2. Imagine you are the nurse at Charleville in this scenario. What are the additional factors you would need to consider in a telehealth consultation?
   (Adapted from Queensland Health 2016)

REFLECTIVE QUESTIONS

1. Consider the health status of rural and remote Australia or New Zealand. What are the major health issues? Identify strategies to improve this situation. How might nurses implement or incorporate these strategies in their practice?
2. Working in a rural setting means nurses often work autonomously with few immediate supports. What type of supports could be introduced to assist rural and remote nurses and reduce burnout?
3. Reflecting back on your undergraduate preparation, what additional skills would you need to work in a rural and remote location? What type of education do you think would prepare you for the role of a beginning rural or remote area nurse?

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CHAPTER 19: CULTURAL SAFETY IN NURSING AND MIDWIFERY

Tamara Power and Kim Usher

KEY WORDS

Australia; colonisation; cultural capability; cultural safety; culturally safe; nursing care; culture; First Peoples; Māori; multiculturalism; New Zealand; social; determinants of health

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- explain the concept of culture;
- define the terms cultural safety and cultural capability and how these concepts inform nursing care;
- discuss culture in the context of nursing and the healthcare system;
- examine the role of cultural safety in improving access to healthcare services;
- reflect and think critically about own values and beliefs when caring for Aboriginal and Torres Strait Islander peoples, Māori and people from other cultural and ethnic backgrounds;
- identify specific considerations for the delivery of culturally safe nursing care for Aboriginal and Torres Strait Islander peoples, Māori and people from other cultural and ethnic backgrounds;
- understand how the social determinants of health can impact those who are not part of the dominant culture.

INTRODUCTION

Australia and New Zealand's populations are becoming increasingly culturally and socially diverse due to immigration. To provide effective nursing and midwifery care for all people, nurses and midwives need to be adaptable and able to accommodate cultural considerations and differing constructs of health in their work. In recognition of Indigenous Peoples as the original inhabitants, and their unique healthcare needs that stem from a history of colonisation, marginalisation and racism in both Australia and New Zealand, this chapter will differentiate the healthcare needs of Indigenous Peoples from the needs of people from other culturally and linguistically diverse (CALD) backgrounds.

Before reading this chapter

Open a blank document on your computer or find a piece of paper and a pen. Write down a definition of culture. What do you think it means? How do you think culture influences nursing and midwifery practices? List any cultures you believe you belong to. Try and think more broadly than just your ethnicity.

Culture

Culture is a multi-faceted phenomenon that encompasses the common beliefs, values, behaviours, traditions and symbols of a group of people. Within a culture, particular behaviours are socially transmitted and nurtured (Drevdahl 2018, Ting-Toomey & Dorjee 2019). Although frequently associated with ethnicity, the concept of culture is broader and the word is used generally to describe subcultures, or groups of people with shared values who live similar lives. Belonging to a culture, cultural practices and identity, enhances survival, adaptation to the environment and social and emotional wellbeing (Taylor & Thompson Guerin 2019, Ting-Toomey & Dorjee 2019, Wilson et al 2019).

The concept of culture and its relationship to nursing

CULTURE IS DYNAMIC

The Nursing Council of New Zealand (NCNZ 2016) defines the concept of culture as 'the beliefs and practices common to any particular group of people' under the broad categories of: 'age or generation, gender, sexual orientation, occupation and socio-economic status, ethnic origin or migrant experience, religious or spiritual belief and disability' (32). A number of authors argue that assigning a set of differences to each of the categories that people other than the dominant cultural group can use as a method of identification or signification, is an essentialist view of culture (Blanchet Garneau & Pepin 2015, Cormack et al 2019, Drevdahl 2018) which can marginalise individuals in the context of mainstream healthcare services. Using an essentialist definition of culture

implies that cultures are static, that there are a set of characteristics and issues that members of each cultural group face regardless of context and that these cultural norms are handed down from generation to generation (Blanchet Garneau & Pepin 2015, Taylor & Thompson Guerin 2019). This concept of culture is problematic.

It is important to understand that just because people come from the same culture, it does not mean they will all believe the same things and act in the same way. For example, consider Aboriginal people in Australia; there are hundreds of different groups who speak many different languages. Like all people, Aboriginal people vary in ethnicity, gender, spiritual beliefs and adherence to cultural practices (Best 2018). Assuming all Aboriginal people can be understood as a group with exactly the same beliefs or qualities is misleading or even dangerous. Unfortunately, an essentialist view of culture can result in clinicians developing stereotypes and using a blueprint approach to try to explain the actions of peoples from specific cultural groups (Cox & Taua 2016).

Reformulating the concept of culture as a dynamic process, as opposed to a static entity, informs the concept of cultural constructivism (Blanchet Garneau & Pepin 2015, Cox & Taua 2016) whereby nurses and midwives begin with the individuals with whom they practise, and seek to understand their worldviews and their ways of being and knowing. In using this approach, people of a different culture are not seen as a member of a group with similar beliefs and qualities. Rather, clinicians will work with people from different cultures by seeking to understand each individual as a unique person with qualities and beliefs, while taking their social context into account (Cox & Taua 2016).

Before moving on to the next section, take a moment to reflect on your own definition of culture and decide if your initial ideas have most in common with either an essentialist or constructivist view of culture and think about what has influenced your understanding of 'culture'. Also think about the issues that can arise if culture is conceived as a static rather than dynamic concept.

Cultural safety

Irihapeti Ramsden (2002) has had significant influence in New Zealand and internationally through her contribution to the notion of *cultural safety.* Originally proposed as a political response to the long-term effects of colonisation on the Māori people, cultural safety is situated within a framework of biculturalism between the Māori and non-Māori (immigrant others to New Zealand) with the goal of better healthcare for all (Kurtz et al 2018, Ramsden 2002). Importantly, the notion rests on the principle that culturally safe healthcare is determined by the end-users rather than the healthcare providers (NMBA 2018a, 2018b, Taylor & Thompson Guerin 2019). Cultural safety recognises the importance of individuals, families and communities being able to judge the quality and appropriateness of nursing and midwifery care provided to them (Taylor & Thompson Guerin 2019). The NCNZ (2011) defines cultural safety as:

> *What is effective nursing care of a person or family from another culture is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender;*

sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. Optimally, the nurse delivering culturally appropriate care will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that this has on his or her professional practice. Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

Much has been written about the importance of cultural safety in nursing and midwifery practice, particularly in colonised countries such as New Zealand and Australia which are becoming increasingly multicultural and diverse. To guide all healthcare delivery, cultural safety is now a pivotal component of all nursing and midwifery curricula (Australian Nursing and Midwifery Accreditation Council 2012, NCNZ 2019) and nursing and midwifery registration (Nursing and Midwifery Board of Australia 2016, 2018c, NCNZ 2011). Cultural safety is not about developing in-depth knowledge about diverse cultures. It is about addressing structural inequities and power imbalances in health, education and research. Grounded in critical social theory, cultural safety calls upon health professionals to continually reflect on their own socio-political contexts and how these influence their values, beliefs, assumptions and professional practice (Cox & Taua 2016, NMBA 2018b). 'Cultural safety provides a … model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgement of white privilege … to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters' (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives 2017:11, NMBA 2018b). Every person seeking healthcare should be considered a unique mix of ethnicity, gender, ability, social class, age and any other variables (Cox & Taua 2016). We will return to the concept of cultural safety and how you embed it in your nursing practice later in this chapter.

Aboriginal and Torres Strait Islander peoples in Australia

Australia's First Peoples consist of two distinct groups, Aboriginal peoples and Torres Strait Islander people. In 2016 there were nearly 800,000 self-identified Aboriginal or Torres Strait Islander people in Australia, equalling 3.3% of the total Australian population (AIHW 2019). Despite their right to equal health status, Aboriginal and Torres Strait Islander peoples suffer health disparities when compared with non-Indigenous populations (Australian Indigenous Health*Info*Net 2019). For example, while the life expectancy of Australians is high when compared with that of the rest of the world, the life expectancy of Australia's First Peoples is among the lowest worldwide (less 10.2–10.8 years for men and 9.6–10.6 years for women) and they continue to experience poorer health and higher death rates than non-Indigenous Australians (AIHW 2017). Aboriginal and Torres Strait Islander peoples in Australia are hospitalised for intentional self-harm at 2.7 times the rate of the general population (AIHW 2018a). The suicide rate is also double (Australian Indigenous Health*Info*Net 2019). Aboriginal and Torres Strait Islander peoples have a 50% chance of surviving five

years after a cancer diagnosis, compared with a 65% survival rate for non-Indigenous people (Australian Indigenous Health*Ingo*Net 2019). For further information on the social determinants of health for Australia's First Peoples refer to Chapter 16.

The marked disparity in health can be directly attributed to colonisation and resulting marginalisation and discrimination (Wilson et al 2019). Prior to colonisation, Australia's First Peoples enjoyed a healthy, active lifestyle that included governance of the land and natural resources. Their lives and societies were complex, and rich with tradition and spiritual practices (Sherwood 2018). The arrival of British settlers in 1788 marked the beginning of systematic cultural destruction resulting in the loss of language, ceremony and customs; separation from country and natural resources; the introduction of devastating diseases; and racist policies and practices that disintegrated families and kinship networks (Cox & Taua 2016, Sherwood 2018, Wilson et al 2019).

Despite their poorer health, many Aboriginal and Torres Strait Islander peoples are reluctant to access health services because of the reliance on Westernised biomedical models of service delivery that fail to accommodate alternative constructions of health (Sherwood 2018). A lack of culturally capable practitioners providing care in settings that support cultural safety practices results in reduced access to health services. Discrimination and systematic racism in mainstream health services is well documented (Aitken & Seaton 2019).

One important strategy to reduce the health disparity is the education and recruitment of Indigenous health professionals. Indigenous health professionals bring an understanding of shared history, cultural skills and knowledge and contribute to culturally safe healthcare (Wilson et al 2019).

Māori people in New Zealand

In New Zealand, Māori people represent 16.5% of the population (Stats NZ 2019). Like other colonised peoples, Māori have poorer health and social outcomes than other New Zealanders. While non-Māori life expectancy has continued to improve, there has been little change in the life expectancy of Māori. Similarly to Australian Aboriginal and Torres Strait Islander peoples, the disparity in health can be attributed to colonisation, historical trauma, damage to culture and family networks and racist policies and practices (Reid et al 2019, Wilson et al 2019). Māori have longer and slower pathways through the healthcare system and also experience difficulty accessing cultural and affordable healthcare (Reid et al 2019).

The Treaty of Waitangi (Te Tiriti o Waitangi), signed in 1840, is the founding document of New Zealand. The Treaty is the basis for all legislation, and its principles are incorporated into all health service initiatives in New Zealand (Came et al 2018). The Treaty contains three Articles: Article 1 (Kāwanatanga) refers to self-governance, Article 2 (Tino Rangati-ratanga) to Māori self-determination and Article 3 to the rights and protection of Māori (Orange 1989). The Treaty is simplified into three guiding principles: partnership, participation and protection. Together, these form the basis of cultural safety within the New Zealand health services and are intended to guide health service delivery (Came et al 2018, Cox & Taua 2016). However, there is a current debate that reference to these principles in health policies is sparse and largely rhetorical

(Came et al 2018). The continuing disparities in Māori health has led to a tribunal to investigate the enactment of the Treaty of Waitangi in primary healthcare (Waitangi Tribunal 2019).

See Box 19.1 for other key dates in New Zealand's history.

BOX 19.1 Key dates in New Zealand's history

1300	East Polynesian people arrive—now known as Māori
1642	Abel Tasman visits
1769	James Cook arrives and claims New Zealand for Great Britain
1835	Declaration of Independence signed by 34 Māori chiefs
1840	Treaty of Waitangi
1865	Wellington declared capital in place of Auckland
1893	New Zealand becomes the first country to give all women the right to vote
1907	New Zealand becomes a dominion
1908	Population reaches 1 million
1933	Adopts own currency
1947	Adopts the Statute of Westminster (1931) and becomes independent of Great Britain
1952	Population reaches 2 million
1967	Decimalisation of currency
1973	Population reaches 3 million
1983	Closer Economic Relations (CER) agreement signed with Australia
1985	Waitangi Tribunal given power to hear Māori land grievances going back to 1840
2003	Population reaches 4 million
2020	Population reaches 5 million

Box 19.2 identifies some suggestions to consider when working with First Nation's peoples. It is important to remember not to expect individuals from a particular culture to be uniform; hence, these are offered as suggestions only.

BOX 19.2 Working with Indigenous people

Things to be aware of when working with Indigenous people include:

- Indigenous people perceive health and illness differently from the Western biomedical model. Be sensitive to alternative worldviews.

- It may not be appropriate for a nurse to care for an Indigenous consumer of a different gender. Where possible ask that a nurse of the same gender is assigned to care for that person or ask if a family member is able to assist in any way. If this is not possible, explore solutions with the consumer; for example, delaying personal care till the next shift.

- Indigenous consumers must be consulted and included in all decisions about their care. Sometimes this may also mean involving family members.

Be guided by the consumer in this matter. Indigenous consumers often have an extended family and group of carers who all should be consulted.

- Avoid asking questions about ceremonial business, bereavement, sexuality, fertility, domestic habits and other similar sensitive issues. If you are unsure regarding what is appropriate to ask, meet with an Aboriginal Liaison Officer for guidance. Engage in ongoing professional development regarding Indigenous culture.

Adapted from Haswell et al 2009, Westerman 2004.

Multicultural Australia

Despite anti-immigration rhetoric, Australia has been referred to as a multicultural success story. This stems from measures of migrant peoples' 'assimilation, integration and adaptation' which is evidenced through things like the educational success of their children (Rajadurai 2018:2). Australia has one of the largest proportions of immigrant populations in the world, with an estimated 29.7% of the total population born overseas (Australian Bureau of Statistics 2020). A further 21% of second-generation Australians (born in Australia) had at least one parent born overseas (Australian Bureau of Statistics 2017). The proportion of people who only speak English at home is decreasing. In the 2011 census 76.8% of Australians only spoke English at home. This figure dropped to 72.7% in the 2016 census (Australian Bureau of Statistics 2017).

The Australian Government (2017:4) describes multiculturalism as being: '… one of our greatest strengths; … that equips us to build a future where everyone belongs and has the chance to live a great life.'

From a historical perspective, Australia's policies on immigration have evolved in response to social changes and a commitment to the development of society as a whole (see Table 19.1). Since 1947, Australia's immigration policies have shifted between phases of assimilation, integration, multiculturalism and mainstreaming, to inclusiveness and being united in diversity.

TABLE 19.1

Periods in Australian immigration policy development

YEARS		FEATURES	HEALTH POLICY IMPLICATION
1945–70	Assimilation	Predominantly White Australian Anglo-Saxon policies.	Absence of government assistance.
1970–80	Integration	White Australia policy relaxed and gradually abandoned. Some cultural characteristics tolerated.	Relevant services provided. Welfare needs of migrants being addressed.
1980–89	Multiculturalism	Pluralistic approach to immigration. Policies to limit discrimination on racial and ethnic grounds. Cultural and ethnic diversity becoming more accepted in Australian society. Cultural identity, social justice and economic efficiency were adopted.	Provision of various health services. Equality of access to culturally appropriate services.
1983	Mainstreaming	Redirecting service delivery from marginal to a central base. Concern of government institutions based on social equity and access; economic efficiency and cultural identity.	Promotion of culturally sensitive health services. Equality of access to health services by immigrants.
1999	Inclusiveness	Diversity. Multicultural policies built upon civic duty, cultural respect, social equity and productive diversity. The term *multiculturalism* to remain. Inclusiveness.	Promotion of culturally sensitive health services. Equality of access to health services by immigrants.
2000–08	United in diversity	National agenda for a multicultural Australia. Policy framework including: all Australians are expected to have a 'loyalty to Australia and its people, and to respect the basic structures and principles underpinning our democratic Society. These are: Constitution, Parliamentary democracy, freedom of speech and religion, English as the National language, the rule of law, acceptance and equality' (Commonwealth of Australia 2008:1–2).	Main components of 'Multicultural Australia: united in diversity policy 2003–06': responsibility, respect, fairness and benefits for all.
2008–12	Benefits of cultural diversity	Celebrate and value the benefits of cultural diversity. Emphasis on justice, inclusivity, trade, racism and discrimination.	The People of Australia: Australia's multicultural policy launched in 2011.
2013–17	Strength in diversity	Recognise the strength inherent in a multicultural society.	Multicultural Australia —united, strong, successful: multicultural statement released 2017

Source: Commonwealth of Australia 1999, 2003, 2008, Department of Home Affairs 2020, Spinks 2009

Australia's current multicultural statement (Australian Government 2017) is underpinned by shared values, rights and responsibilities, including '… respect, equality and freedom … rule of law, gender equality, freedom of religion, speech and thought' (Australian Human Rights Commission 2017:6).

Multicultural New Zealand

New Zealand has a diverse multicultural population of approximately 4.7 million people (Stats NZ 2019). While British migrants predominated during the first half of the twentieth century, the 1950s saw an increasing number of migrants come from the Pacific Island countries. However, since the 1990s there has been a rapid diversification of migrants arriving in New Zealand with increasing numbers of migrants arriving

from Asia. In the 2018 census over a quarter of the total New Zealand population had been born overseas (Stats NZ 2020). In the 2018 census, 70.2% of New Zealanders claimed European ancestry, Māori represented 16.5%, Asian people accounted for 15.1% and Pacific Islanders 8.1% (Stats NZ 2019).

Refugees and asylum seekers

The United Nations estimated that approximately 1.4 million people would be seeking refugee status in 2019. The Australian Government's Humanitarian Program aims to protect refugees who have been forced to leave their country due to a dereliction of human rights and warfare. In 2017–18, a total of 16,250 visas were granted under the Humanitarian Program (Department of Home Affairs 2019). Over 53% (7909) of these places were provided to refugees, including 2126 to women and their families considered at risk. Reflecting political unrest, war and conflict, in 2017–18 the top five countries of origin of offshore refugee and Special Humanitarian Program entrants were from Iraq, Syria, Myanmar, Congo and Afghanistan (Department of Home Affairs 2019). Since 2013, the Australian Government has only granted onshore visas to people who arrive in Australia through lawful channels (Department of Home Affairs 2019).

Refugees and asylum seekers have complex health needs. Refugees may have experienced severe deprivation, trauma and torture that can lead to post-traumatic stress disorder (PTSD), a condition that can profoundly affect a person's health and capacity to resettle. Despite the provision of comprehensive and cost-effective primary healthcare, refugees face barriers to access such as lack of familiarity with the health system, differing health beliefs and/or cultural and language barriers, and lack of cultural awareness among health professionals (Au et al 2019). In addition, many newly arrived immigrants and refugees transfer to regional and rural locations for employment and affordable housing (Piper 2017). However, social support networks and access to culturally appropriate services are reduced in regional areas, in comparison with urban and metropolitan regions in Australia, which adds to the barriers to access.

Correlations between disadvantage and the social determinants of health

The World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity (WHO 2019). The degree to which a society experiences health and wellbeing is largely dependent upon the social and cultural structures in place to support the nation's most vulnerable population groups (AIHW 2018b). Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives, higher levels of disease risk factors and lower use of preventive health services. As previously mentioned in this chapter, Australia and New Zealand's Indigenous populations have some of the worst health indicators globally (for further information, refer to Chapter 16 Health disparities: the social determinants of health).

In contrast to the poor health status of Australian and New Zealand Indigenous peoples, most immigrants to these countries enjoy health that is at least as good as, if not better than, that of the Australian-born population. Immigrants often have lower death and hospitalisation rates, as well as lower rates of disability and lifestyle-related risk factors (AIHW 2018b). The 'healthy migrant effect' is believed to result from two main factors. First, a self-selection process includes those who are willing and economically able to migrate and excludes those who are sick or disabled. Second, the government selection process involves certain eligibility criteria based on health, education, language and job skills (AIHW 2018b). However, as migrants acculturate to their host country and make changes to lifestyle factors such as diet, the healthy migrant effect tends to deteriorate with increased length of stay. This is particularly evident in people from non-English-speaking backgrounds (AIHW 2018b).

Providing culturally safe nursing care

In New Zealand, cultural safety education is underpinned by five principles. These principles address 'communication, recognition of the diversity in worldviews (both within and between cultural groups), and the impact of colonisation processes on minority groups' (NCNZ 2011:4). As it is beyond the scope of this chapter to explore the five principles in depth, we will instead discuss the overarching elements involved in achieving cultural safety in practice (see Fig. 19.1).

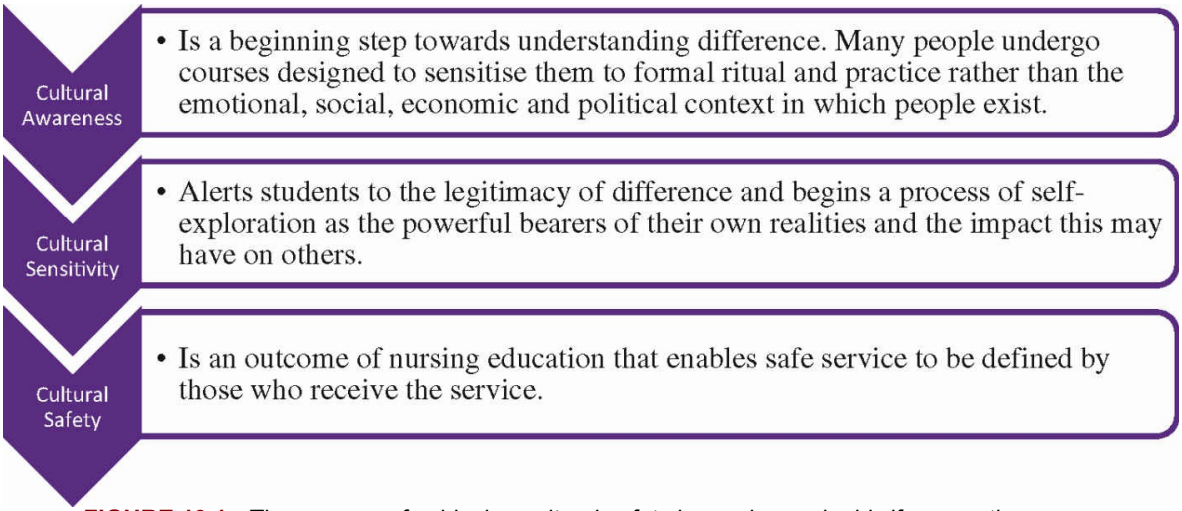

FIGURE 19.1 The process of achieving cultural safety in nursing and midwifery practice

CULTURAL AWARENESS

Cultural awareness is defined as 'understanding that differences exist' (Australian Human Rights Commission 2018:4). Developing cultural awareness is considered the first step towards cultural safety. In the context of working towards providing culturally safe care, it is important to understand that culturally safe practice is

considerate of difference. It is also important to be aware of how cultures might be similar. Although this sounds like an easy thing to do, cultural awareness does not come naturally and must be cultivated (Taylor & Thompson Guerin 2019).

The objective is to care for a person in a way that respects their individual values and beliefs, culture and history (Cox & Taua 2016, Ramsden 2002). Attempting to treat every person the same, fails to take into account inequitable access to privilege and opportunity (Cox & Taua 2016, Taylor & Thompson Guerin 2019). Once differences are acknowledged, their legitimacy can be accepted (Australian Human Rights Commission 2018).

CULTURAL SENSITIVITY

Accepting that all people are different is the beginning of developing cultural sensitivity. Cultural sensitivity is further developed through nurses and midwives reflecting on how their own cultures and life experiences influence their attitudes, values and beliefs about people from other cultures (Australian Human Rights Commission 2018), and ability to care for others. Cultural sensitivity is described as '… the ability to recognise, understand, and react appropriately to behaviours of persons who belong to a cultural or ethnic group that differs substantially from one's own' (Brooks et al 2019:385). In other words, cultural sensitivity is about applying knowledge gained from developing cultural awareness (Taylor & Thompson Guerin 2019). To be culturally sensitive, Best (2018:58), citing Cox and Taua (2013), stated nurses and midwives need to consider:

- their cultural identity
- their assumptions about health, illness and people
- their personal definitions of health
- their patients' definition of health
- whose definitions of health are legitimised (by law and society)
- the implications of these definitions for nursing practice
- the consequences of these definitions for clients' healthcare.

It is also important that nurses and midwives reflect on how the colonial histories of both Australia and New Zealand have influenced issues of power and control in healthcare. Both healthcare systems are based on a 'white' biomedical model. This has resulted in an uneven power differential, inequity in health outcomes and structural racism (Best 2018, Cox & Taua 2016).

Reflecting on the beginning activity, where you were asked to list the cultures you belong to, how do you think these cultures impact on your values and beliefs about

other people?

CULTURAL SAFETY

Cultural awareness and cultural sensitivity precede cultural safety. Aspiring to be a culturally safe health professional means nurses and midwives have engaged in significant self-reflection on their own culture. They have thought deeply about the historical and social influences that govern healthcare in their countries and how this has manifested in biomedical dominance and power imbalances (Best 2018). Culturally safe nurses and midwives also seek to mitigate these imbalances through striving to improve the system from within (NCNZ 2011). They actively seek to reduce power imbalances between themselves and those they care for, through engaging authentically and respectfully with individuals to ensure that they understand their priorities, preferences and beliefs about health and healthcare (Best 2018). Culturally safe health professionals actively try to avoid cultural harm (Taylor & Thompson Guerin 2019). They build rapport with their patients through respectful communication that involves active listening and responding appropriately to verbal and non-verbal cues (Brooks et al 2019). Where appropriate, patients' families are included in care planning and decision making. Above all, they understand that cultural safety is achieved when the recipient of care feels that their cultural needs have been satisfied (Taylor & Thompson Guerin 2019).

CONCLUSION

Meeting the healthcare needs of individuals living in multicultural countries such as Australia and New Zealand requires careful reflection and consideration on behalf of nurses and midwives. This chapter has provided an overview of each country's Indigenous and CALD populations and the ways this composition impacts on the role and function of nurses and midwives. The importance of understanding culture as a dynamic process was also addressed. A number of strategies to promote critical thinking and reflective practice around particular issues that impact on nursing and midwifery care are provided.

REFLECTIVE QUESTIONS

1. What are some of the factors influencing healthcare for diverse populations in Australia and New Zealand? Reflect upon those discussed in this chapter.
2. How are social context and cultural beliefs linked to health and wellbeing outcomes?
3. Take some time to think about your own cultural beliefs in relation to health and healthcare. How might your own beliefs be similar or different from those of someone from another culture?
4. Why is it important to change the existing view of culture from a static to a dynamic process?
5. What factors may be important to consider when delivering care to a recently arrived refugee?

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CHAPTER 20: CONNECTING CLINICAL AND THEORETICAL KNOWLEDGE FOR PRACTICE

Jane Conway

KEY WORDS

accountability; clinical decision; making; clinical learning; curriculum; lifelong learning; theory-practice; transition

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- value both clinical and theoretical knowledge in nursing and appreciate the need to integrate clinical and theoretical knowledge for lifelong learning and professional development;
- identify personal attributes and strategies that maximise the acquisition of clinical and theoretical knowledge;
- explain the concept of knowledge-ABILITY and its relationship to nursing practice.

INTRODUCTION

This chapter is designed to encourage nurses to view learning as a continuum of development and lifelong learning that has the unifying goal of achieving and maintaining competence within the complexities of contemporary practice. The chapter explores the term knowledge-ABILITY in order to reinforce the importance of being able to connect clinical and theoretical knowledge for nursing practice. The importance of both the 'classroom' and clinical setting for learning is discussed. It is suggested that although connecting clinical and theoretical knowledge has been argued to be difficult for students, the development of a set of abilities for learning is essential for effective practice and career development in nursing. In this chapter, the term 'classroom' is used to describe those learning experiences that do not require students to participate in clinical activity, acknowledging that web-based and other technology enables people to learn without being co-located in classrooms.

As the transition from student to graduate can be a particular period during which nurses need to enact their knowledge-ABILITY, the importance of having developed a range of strategies that assist in integrating clinical and theoretical knowledge during transition is emphasised.

Connecting clinical and theoretical learning to become knowledge-ABLE

'Nursing is situated in a field between a practice discipline and an academic discipline' (Hoeck & Delmar 2018:3). Therefore, the capacity to respond appropriately and effectively in nursing practice is dependent upon the extent to which one connects clinical and theoretical knowledge in order to make sense of situations. Such sense making requires knowledge-ABILITY. The concept of knowledge-ABILITY requires that learners are able to connect and use both clinical and theoretical knowledge. In her often cited classical work about the development of registered nurses, Benner (1984) has identified that the ability to integrate theory and practice to the point of being able to generalise is essential to development from novice (newly qualified) to more advanced levels of nurse. Effective clinicians are aware that context is the crucial moderator (Johns 2018) in nursing practice, and have developed mechanisms for managing situations contextually, rather than seeking to manage all situations in the same way (Conway & McMillan 2019).

Expanding upon this, we believe there is a need for learners to be able to transfer concepts between the learning cultures typical of classroom and clinical environments. Furthermore, there is a need for graduates to continue this as they transition to practice. We recognise the majority of student nurses see working in clinical practice as their initial career goal and we aim to reinforce to readers that, throughout their learning as students, they will acquire a set of knowledge and skills in both nursing and learning.

Classroom and clinical educators, lecturers and clinicians often declare that they have a shared goal of ensuring quality education for nursing students. However, each of

these sectors of the nursing community has what, at times, may seem to be very different definitions of nursing and, within that, different expectations of students and graduates. This results in what students may perceive as a lack of alignment between the values of, and experiences in, the education and health service sectors. While much of this perceived lack of alignment is attributed to what has been described as the theory–practice gap (Greenway et al 2019), nursing education has a single unifying focus—to assist people to be nurses. Being a nurse requires the ability to actively respond with nursing interventions, to think about the clinical judgements made and the consequences of action taken and to develop a capacity to articulate that thinking to others. It is necessary to encourage people to embrace any perceived theory–practice gap they experience as an opportunity to learn, rather than an opportunity to criticise nursing practice or education. A key way of doing that is to become more knowledge-ABLE.

As a nurse you bring an individual approach to the integration of empirical, personal, aesthetic, moral and practice knowledge (Chinn & Kramer 2015). In doing so, nurses as health professionals demonstrate the knowledge-intensive capabilities necessary to provide highly professional services to the community (Carroll 2019, Švarc 2015). More than ever before, contemporary health service delivery demands that nurses demonstrate the full suite of skills representative of the knowledge-ABLE worker. The knowledge-ABLE worker aspires to enhance patient and staff safety, minimise adverse circumstances, promote partnership initiatives, focus on 'fitness-to-function' and acknowledge that health service delivery is dependent upon multi-professional team effort.

Thus, the student nurse as a knowledge-ABLE learner sees connections between clinical and theoretical knowledge of nursing within a broader framework of learning that integrates his or her experience and enables the outcomes of education to be applied in order to practise nursing as a knowledge-ABLE worker.

The knowledge-ABLE nurse develops awareness that the range of factors beyond the immediate client care situation impact upon nursing. Examining the political, economic, technological and socio-cultural (PETS) factors that have an impact on client care is useful. When nurses seek to enhance their knowledge-ABILITY, they should reflect upon the extent to which these factors shape what constitutes nursing work. Fig. 20.1 provides an example of the application of PETS to delivery of nursing services. Table 20.1 presents some of the factors that shape contemporary healthcare delivery and desired knowledge-ABLE worker responses. The table indicates that although the factors that impact on health service delivery and healthcare work can be viewed in isolation, nurses, as knowledge-ABLE workers, require a range of clinical and theoretical knowledge acquired through a multifaceted education in order to respond meaningfully to the challenges in contemporary health service provision.

TABLE 20.1

Worker responses to a changing health service

HEALTH SERVICE CHALLENGES	KNOWLEDGE-ABLE WORKER RESPONSE
Technology: clinical and information systems interface. Fragmented patient experience. Changing health patterns: chronicity and consumerism. Changing workforce: unaligned skill mix and case mix. Inappropriate structures and processes. Changing professional roles and functions. Rigidity in professional frameworks and knowledge bases.	Procedurally competent, information-fluent personnel. Contributors to systems review. Effective managers of consumer expectations, competing value systems and tensions in resource allocation. Coordinators of throughput and care processes. Participants in networked organisation and healthcare teams. Personnel who focus on consumer needs and outcomes rather than profession-specific outcomes.

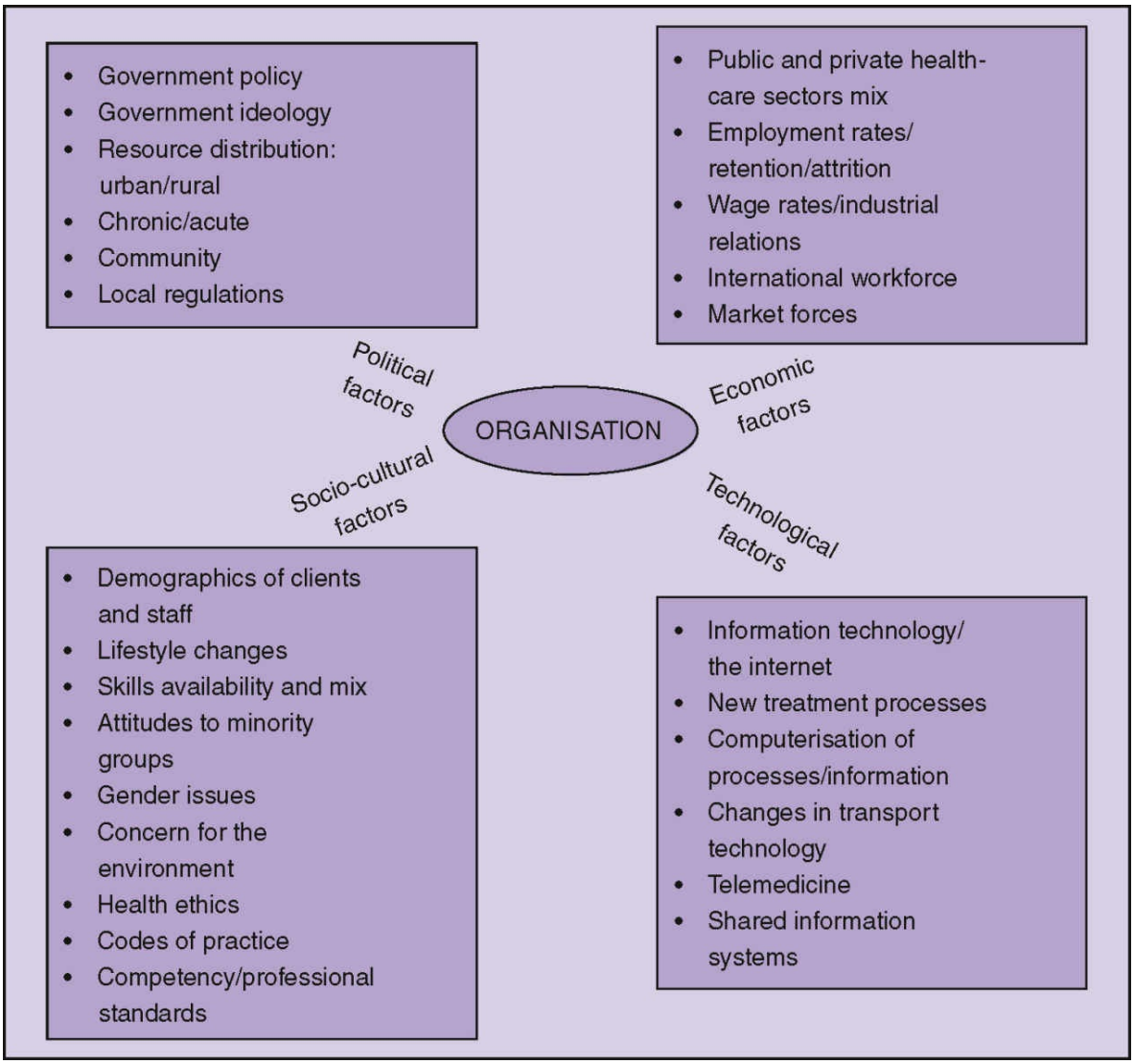

FIGURE 20.1 Application of the PETS framework to explore professional change in nursing

In formal education in both vocational and higher education, the accredited nursing curriculum provides structure to a student's learning and is designed to integrate clinical and theoretical learning to develop the knowledge, skills and behaviours that result in competent beginning practice. Learning events should cause students to be actively engaged in thinking about what they do as nurses, why they do what they do and how they might do it differently. Beyond graduation, nurses are expected to frame work experiences as learning experiences and draw upon their abilities as lifelong learners, reflective practitioners and information-literate graduates who appreciate the importance of continuing professional development (Nursing and Midwifery Board of Australia (NMBA) 2016).

Nursing education programs include both classroom and clinical learning experiences, which provide students with opportunities to practise the skills of nursing, to develop and demonstrate their knowledge base about nursing and to acquire

academic skills that support communication of their thinking about nursing. The overarching structure of all nursing courses is the nursing curriculum, which determines both the outcomes that should be achieved and the processes by which these will be achieved. Increasingly, nursing curricula use problem-based teaching and other constructivist strategies to encourage development of the knowledge, skills and behaviours of effective clinicians. This type of learning fosters exploration of 'real-life' situations to enhance critical thinking and clinical decision making (Wosinski et al 2018). It aims to enhance knowledge-ABILITY rather than information acquisition or the tasks of nursing work. Fig. 20.2 represents the relationships between context and lifelong learning processes and curriculum and improved practice.

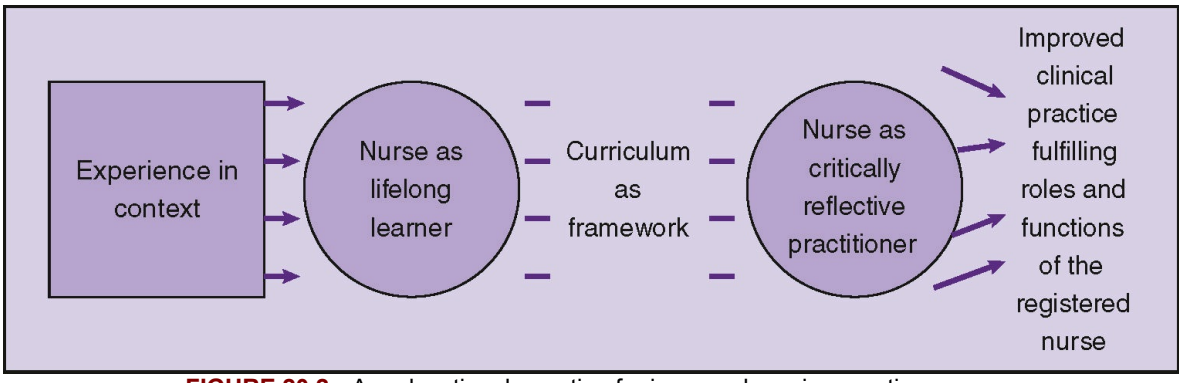

FIGURE 20.2 An educational equation for improved nursing practice

It is imperative that learners, be they students, recent graduates or experienced professionals, capitalise on events that foster their ability to critically analyse situations, identify underpinning knowledge and ideas and critically appraise their own professional development. These abilities underpin nursing competency and are often linked to the idea of being a lifelong, inquiring learner (NMBA 2016), and are seen as increasingly important to professional nursing practice in the twenty-first century (Masters & Gilmore 2018).

Achieving improved practice and knowledge-ABILITY through connecting clinical and theoretical knowledge requires active development of the process skills of lifelong learning, including reflective practice, acceptance of the outcomes of appraisal and effective use of learning resources, including peers and people with qualification and experience such as clinical facilitators and nurses in the workplace.

Developing knowledge-ABILITY

Classroom learning activity provides a relatively safe environment to explore what we know, what we do and who we are as nurses, so that we are more prepared for professional practice situations. Clinical learning activity provides the opportunity both to test out what has been learnt in practice and to confront new situations to further your learning. However, you can only learn if you are prepared to do so. It is important to value learning as much as you value what you have learnt.

In order to learn, you need to develop the process skills for lifelong learning. These process skills facilitate the progression from student to graduate and the development of nursing expertise along what Benner (1984) has described as a continuum from novice to expert nurse. Nursing knowledge provides specific content which, when processed, results in nursing action. That is to say, when we become nurses, we have developed general learning skills and we demonstrate our use of these through being able to 'think and act like a nurse'. In order to be lifelong learners in relation to nursing practice, there is a need to become what has been termed reflective practitioners. You need to reflect about what you do as nurses, how you respond as nurses and individuals and what you would do again in a similar situation. You then need to act when a similar situation occurs. Chapter 6 explains more about the development of reflection and provides particular tools for reflecting on clinical practice.

Many educational theorists have consistently highlighted the importance of being reflective practitioners and lifelong learners in order to be, both personally and professionally, constantly transformed and emancipated from previous ways of thinking and acting (Brookfield 1993, Cranton 1994, Friere 1972, Mezirow 1985, Taylor 2008). The skills of reflective practice unite theoretical and clinical knowledge, are both thought-oriented and action-oriented, allow for consideration of the affective aspects of nursing experience and provide opportunity to explore how the learner as a reflective practitioner felt about the experience. Such an approach is particularly useful in nursing, as it acknowledges human and emotional, as well as intellectual, domains of decision making and encourages self-regulation and autonomy in learning.

There are a number of useful frameworks for situation analysis that are oriented towards integrating thinking and action for learning. Gibbs (1988) developed a cycle that encourages systematic thinking about situations as learning events (see Fig. 20.3). Gibbs' processes include a description of the situation, determining thoughts and feelings about the situation, identifying what was good or bad about the experience and analysing the situation in order to draw conclusions and identify responses should a similar situation occur.

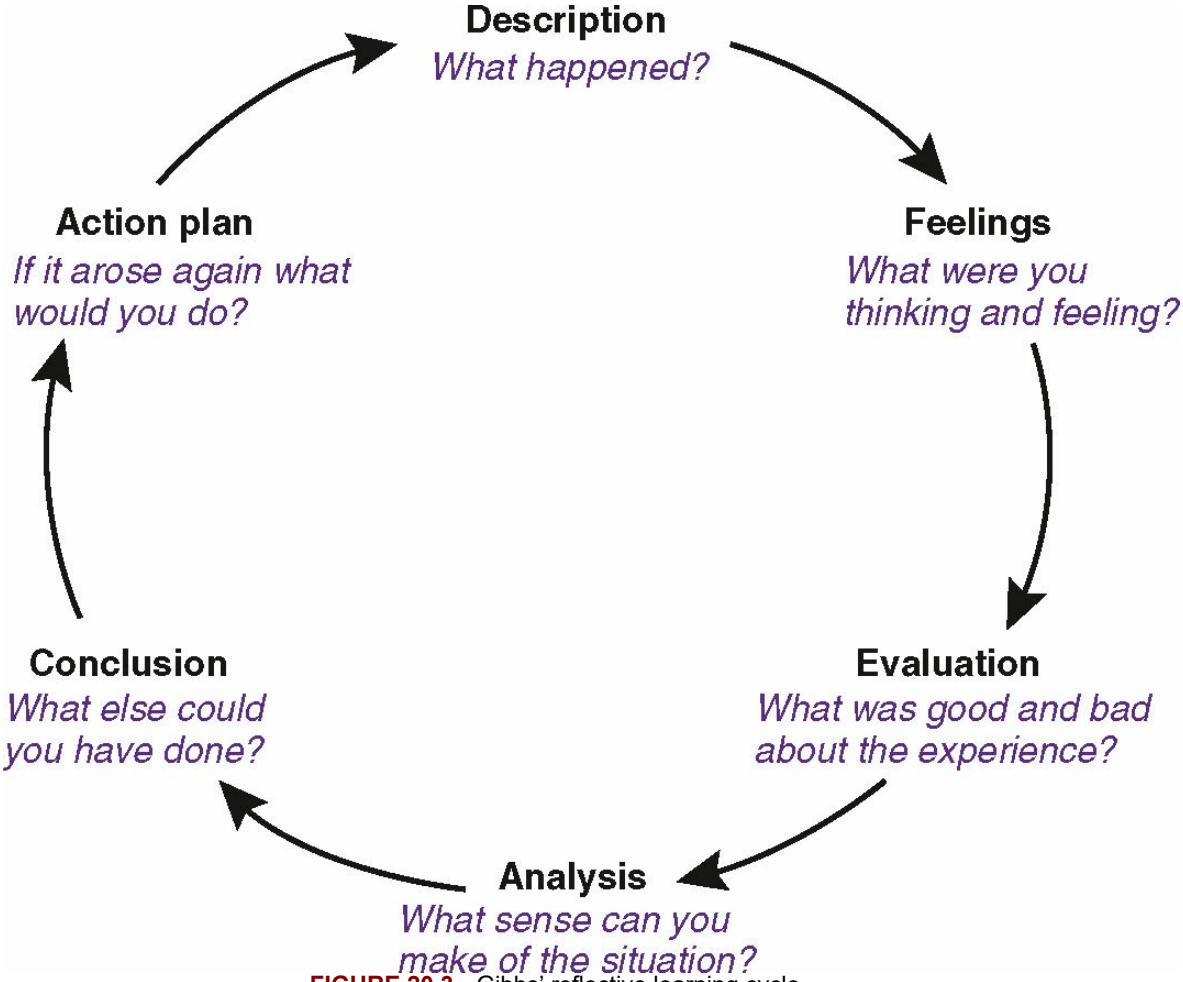

FIGURE 20.3 Gibbs' reflective learning cycle
The reflective cycle was originally published in Gibbs 1988. *This book is now available to download as an ebook from the website of the Oxford Centre for Staff and Learning Development, Oxford Brookes University at* http://www.brookes.ac.uk/ocsld/publications/

Little (1996 cited in Conway & McMillan 2019) elaborated upon the elements of Gibbs' framework to develop a framework of questions that facilitate reflection about particular aspects of learning and is applicable in both classroom and clinical learning situations that can be used to facilitate reflection. These questions provide a useful guide to developing lifelong learning skills, yet are equally important questions for clinical decision making. The framework recognises that learning is inherently a personal experience and places emphasis on the subjective nature of learning. In order to be accountable for their practice, nurses need to become subjectively engaged in that practice and examine their perceptions and assumptions. Additionally, the framework integrates the abilities related to information literacy, application and transfer of knowledge and skills to novel situations and learning within a group. This framework of questions is useful because it encourages us to look at situations in context and to focus on learning. It enables greater appreciation that, as learners and professionals who make sound clinical judgements, nurses are required to interact effectively with others, provide reasoning and support for actions and decisions and be accountable for our

own learning and practice actions. Little's approach is presented in Box 20.1.

BOX 20.1

SITUATION/ANALYSIS OR DECISION MAKING

- What information do I have?
- What further information do I need?
- What options/alternatives do I have?
- What should I prioritise?
- What action/s should I take?
- Why?
- Can I justify this action (lawfully, ethically, effectively, theoretically)?

THE LEARNING PROCESS

- What do I already know?
- How do I know it?
- What do I need to know?
- Where will I find it?
- What resources can I use?
- How will I know I know?
- Why should I learn it?

PERCEPTIONS

- What are my feelings?
- What are my beliefs about the situation?
- What are my assumptions?

- How have I derived these beliefs/assumptions?
- How do my feelings/beliefs

- affect my interpretation?
- affect my response?
- relate to espoused professional values?
- Why do I hold this belief/assumption?
- What are alternative beliefs/assumptions?

LEARNING PROCESSES

- What is the validity of my source?

- Legislation
- Data based on research
- Opinion
- Practice
- Expertise
- Experience
- What is the currency of the knowledge, skills, behaviour?
- What is the support for this view?

- Political/ideological
- Cultural

- What other ideas/concepts/skills does it relate to?
- How does it relate to my view of the world (current understanding)?

THE SITUATION REVISITED

- How does my learning relate to/apply in this situation?
- How does my learning relate to/affect my original ideas?
- What gaps/misconceptions did my learning identify?
- What ideas/skills did my learning confirm?
- What response would I give now in the situation?

REFLECT ON:

Situation analysis

- How well did I use the data?
- How well did I define the situation in need of a response?
- How comprehensive were my alternatives?
- How well can I justify my response?

The learning process

- How valid/relevant were my sources?
- How comprehensive were my sources?
- How effective was my learning?

The group process

- How well did I contribute?
- What was my role in the group?
- How effective was each member's contribution?

- Did the group remain on task?

- Did the group attend to process (i.e. how people were feeling/responding/behaving)?

Knowledge-ABILITY as action-oriented active learning

Ultimately, professional accountability is related to actions, not a capacity to generate ideas. Although theory is important, because it provides a framework for the work nurses do, it is of little consequence unless it results in effective nursing actions. Conversely, practice can become meaningless unless nurses seek to understand it through thinking and theorising about the practice of nursing. Such integration of theory and practice leads to movement beyond 'becoming' nurses to 'being' nurses who integrate our knowing, doing and being to produce what is meaningful, client-focused management of situations.

While frameworks for reflection are relevant to a number of practice disciplines, including nursing, there is potential for nurses to utilise the 'learning' components of models such as these selectively and to overlook the critical elements related to action. In responding to the needs of individuals and communities, nursing is both reactive and proactive. As both the guardians of and visionaries for the future of nursing, it is important that students take the opportunity to develop the skills to critically evaluate the nursing practice they observe and to create and consider alternatives to this practice. The imagination of possibilities can only occur when nurses think about nursing. In other words, each of us has a professional responsibility to make a conscious decision to think about our practice and link both our clinical and theoretical knowledge to clearly establish the relationship between our theoretical understandings, judgement and action taking.

A central feature of contemporary nursing curricula is the development of inquiry skills that are essential for learning and practice as well as generating knowledge about nursing. For this reason, it is important that the nursing curriculum raises questions such as: 'What is nursing?', 'What does it mean to nurse?', 'Whom do nurses nurse?', 'Where do nurses nurse?', 'Is nursing the same as caring?' and so on, as well as helping students to learn the task-oriented aspects of how to nurse.

Thinking about nursing needs to both direct and emerge from practice. Through the active process of enquiry, students work with, connect and form the ideas that shape their practice as nurses. The intent here is not to give the impression that nurses should only 'think about' nursing. The goal of nursing programs is to develop a graduate who can apply concepts to practice, manage complex nursing situations and accept accountability for practice. Of course, this also demands skills in doing nursing activities. However, despite registered nurse education being provided by universities for over three decades, many in the public, and some in healthcare delivery, continue to criticise nurses as not being skilled. These critics advocate for a return to 'hospital-based training' rather than an educational experience that recognises that nursing work necessitates a high degree of well-informed and considered decision making. In order to

make effective decisions, nurses require the ability to analyse situations and respond appropriately. How nurses interpret and analyse situations depends upon how they think about them. As their thinking about nursing develops, the meaning given to situations changes and learning occurs. This learning is then taken with us to the next situation and new meanings and experiential knowledge are created. Fig. 20.4 demonstrates the continual process of conceptualisation and reconceptualisation of nursing, which occurs through situation deconstruction, analysis and reconstruction.

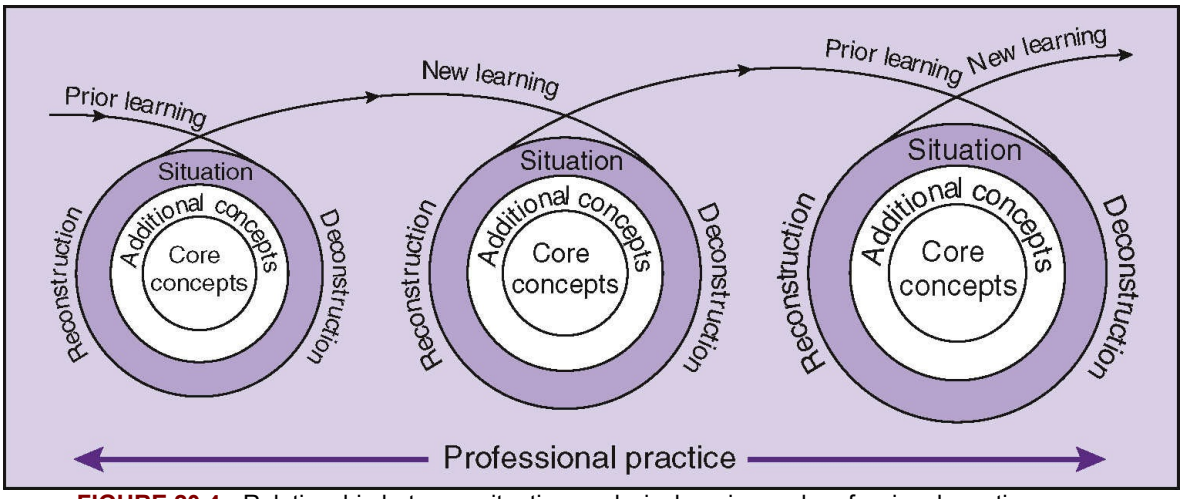

FIGURE 20.4 Relationship between situation analysis, learning and professional practice

Appraisal as a strategy for knowledge-ABILITY

The ability to critically examine and appraise personal performance and be accountable for our own actions is essential to learning and professional career development. This requires the ability to conduct a realistic self-appraisal (Conway & McMillan 2019). Appraisal is a process by which people can:

- confirm outcomes of previous experience
- identify areas of strength
- identify areas for development
- remotivate and energise
- help predict and identify personal potential, and
- acknowledge performance against existing standards.

Appraisal is an ongoing process that can be informed by, but is not limited to, the

formalised feedback sessions that occur among learners and educators. Appraisal consists of assessing accomplishments and performance to make an informed judgement about strengths and limitations in order to identify areas for improvement. It is a mechanism through which nurses can begin to self-manage their performance development (Conway & McMillan 2019).

Feedback is considered an essential part of the appraisal process. It has also been found to promote safe practice and can reduce burnout and disengagement (Sexton et al 2018). You should seek feedback that is constructive and includes comments about things you have done well and areas (and suggested strategies) for improvement where necessary. Clinical facilitators and academic staff can provide such feedback. All too often, feedback can be perceived or experienced as reactive and punitive, rather than as a respectful and meaningful vehicle for development through identifying one's own and others' strengths, availing yourself and others of opportunity and operating within and accepting processes (Phillips et al 2015). Appraisal involves both openness and vulnerability. It should be authentic, active, meaningful and constructive for nurses as well as those they work with as clients and peers. Such critique needs to be managed carefully in order to maintain perspective and avoid overreaction (Kowalski 2017).

Connecting clinical and theoretical knowledge in clinical settings

The public expects a confident, competent nursing workforce that has the capacity to provide comprehensive, person-centred care. Limited clinical learning experiences in which the opportunity to integrate classroom theory in 'real-life' practice situations is provided, may result in nursing students needing to further develop the lifelong learning skills of critical thinking and reflective practice considered important to refining professional practice (Jantzen 2019).

Clinical contexts provide the stimulus for students and practitioners alike to use their skills in order to recognise best practice and, if necessary, enhance and modify existing practice. The changing nature of health service delivery continues to present challenges to both clinicians and students (Byers 2017, Lee et al 2018). In literature related to contemporary health service delivery, it is widely acknowledged that reduced average lengths of stay, an ageing clientele, increased throughput and acuity, developments in healthcare and educational technology and increasing numbers of learners requiring clinical experience impact on the clinical learning milieu and the extent to which it consistently fosters the cognitive skills and confidence required for professional practice (Cummings & Connelly 2016, Ewertsson et al 2015). Well-designed simulated learning experiences have the potential to address challenges in the quality and quantity of clinical placement (Bruce et al 2019) as well as promote sound judgement and enhance appreciation of professional accountability and ethical decision making (Basak & Cerit 2019, Bussard 2015). The stimulus for such learning may be a clinical practice experience or a new insight gained through examining theories, concepts and best available evidence. It has been reported that when nursing students, qualified nurses and their employers are asked to evaluate nursing education, they feel that the time in clinical

placements was inadequate and this has led to suggestions that there needs to be an increase in clinical experience as part of undergraduate learning. However, it may well be that an increase in quality of the clinical experience is preferable to an increase in quantity of clinical placements.

While clinical educators, lecturers and unit staff share in structuring the clinical experience, students are also accountable for ensuring that they gain a quality clinical experience.

This accountability for self-learning closely aligns with the principles of adult learning and ongoing professional development.

Despite the emphasis on critical thinking, problem solving and reflective practice in classroom learning experiences, in clinical settings students are often encouraged to operate routinely and are not challenged to reflect upon their practice in a way that creates intellectual challenge. The principles that underpin learning in the clinical area are used and developed in classroom learning activities. These are transferable across learning contexts. The mistaken belief that clinical and classroom learning are separate entities results in unhelpful commentary about a perceived insurmountable division between the theoretical and the practical aspects of nursing.

Fig. 20.5 depicts the interrelationship between clinical practice knowledge and theoretical knowledge embedded in nursing-specific frameworks. This diagram indicates that clinical activity and other forms of learning are interdependent.

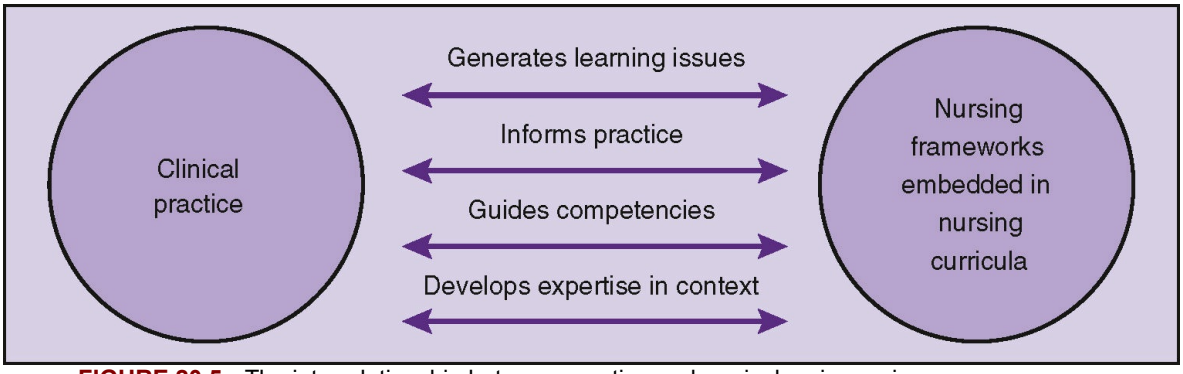

FIGURE 20.5 The interrelationship between practice and curriculum in nursing programs

In order to optimise learning, it is important that each experience be approached as a way of linking theory and practice, and as an opportunity for further learning and generation of new perspectives. Increasingly, nurses are required to engage in roles beyond that of direct patient caregiver and engage in 'systems level intervention', such as contributor in multidisciplinary teams, researcher and manager, through which they facilitate quality patient care. At the very least, students need to think about how the roles and functions that registered nurses perform have shaped, and have been shaped, by the practice situation.

Nursing students should explore roles other than direct caregiver. In most nursing programs the primary emphasis is placed on providing clinical experience in a range of settings (e.g. mental health, acute care and the community). However, it is unclear

whether students are encouraged to explore a range of nursing roles and functions while in those settings. In order to prepare for the diversity of practice, students themselves should analyse each situation and try to determine what nursing roles and competencies are applicable. For example, students in a clinical setting should ask:

- What is the role of the registered nurse here? Is the registered nurse in this context a 'direct caregiver' or a 'care facilitator'?
- Does the role require skills as a clinician, supervisor, researcher, educator, manager or communicator, or a combination of these?
- If I were to be asked to manage this person's situation, what would I do and why?
- What nursing activities are most important and why?
- What knowledge base is required for sound clinical decision making?
- Where does this knowledge come from?
- How do I know what I know?
- What more could I know?
- How could I find out about this?
- How has my response to this situation been shaped by my beliefs about what practice is?
- What strengths do I have to respond to this situation?
- What are my learning needs in response to this situation?

Asking questions such as these encourages us to explore the diverse roles and functions of nurses and to differentiate between the roles of registered nurses and other levels of nurses.

Clinical experiences provide the opportunity for students to observe and participate in nursing practice. Inherent in the notion of effective practice is the ability to make sound clinical judgements based on assessments and reassessments, to collaborate with others, to provide meaningful feedback to colleagues about performances and to establish and maintain professional relationships. Clinical experiences acclimatise students to the real world of practice and its culture, providing preparation for the reality of practice, which is dynamic and replete with novel situations.

Specifically, students and clinicians in the clinical setting are often confused about when students should be observing another's practice and when they should be actively participating in the provision of client care. Understandably, students and clinicians alike want to be opportunistic and seize what they perceive to be limited practice learning opportunities and may, with the very best of intentions, place themselves and the client at risk because they are dealing with situations that are new to them. It would be better for the student to be caused to always consider the need for optimal client outcomes, to be sure of the core objectives and concepts of the clinical placement and determine the relationship between these goals and the activity to be performed. Students need to seek advice from the clinical educator or skilled facilitator about the scope of the student's practice and the need for close supervision.

When students are invited to perform care with which they do not feel comfortable, they might tell the qualified nurse that they are too busy or have other things to do. Sometimes the nurse, who has made an effort to give the student a meaningful learning experience, may interpret this response as disinterest in nursing. In situations such as these, students should recognise the nurse's offer as a way to enhance their learning. The student should explain their situation to the senior nurse on duty, confirm that the qualified nurse is ultimately responsible for the client's care and engage in the activity as far as possible.

Every nurse has a responsibility to integrate theory and practice experiences. Experiential knowledge is not merely being exposed to an experience. It is that which emerges when the experience is structured to achieve learning as an outcome of the experience. Therefore, students should use the theoretical base developed from classroom learning to frame the clinical experience so that learning, rather than merely experiencing, occurs. All nurses in clinical settings should ask themselves: 'What is it that I want to achieve from this learning opportunity and how does this relate to my ability to practise nursing?' With their colleagues in practice and education, students should seek intellectual challenge and appraise one's performance in context.

Connecting clinical and theoretical knowledge to transition to practice

Definitions of clinical teaching and learning invariably include some notion that clinical practice, be it in on campus laboratories or clinical settings, is the place where students apply theory in practice, or where contradictions between theory and practice, and nursing and educational values, are highlighted (Pront & McNeill 2019, Salamonson et al 2015). The ability to provide nursing services within the clinical setting is inclusive of a range of knowledge and abilities and, in Australia, must include the provision of culturally safe healthcare for Aboriginal and Torres Strait Islander people (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives 2017, NMBA 2016).The clinical environment is where students begin to develop professional identities as nurses, but it is only the beginning of the pathway to personal confidence and competence. Development of expertise continues through constant immersion in nursing work throughout the postgraduate period and beyond (Chang & Daly 2019).

Being a nurse requires the ability to integrate the knowledge, skills and attitudes of nursing into who we are and how we practise. Moreover, personal life skills and formal learning should have contributed to graduates developing the capacity to function in novel clinical situations and to work collaboratively with other healthcare workers and an increasingly informed clientele. Developing personal resilience is critical while maintaining appropriate levels of professional expertise, conduct and values. A key component of resilience is confidence related to knowledge and 'the ability to adapt and influence changing scopes of practice, health care needs, and a dynamic health care system' (Waddell et al 2015:161).

Individuals, employers, supervisors, education bodies and regulatory authorities have a collective responsibility to ensure that the knowledge and skills base from which a nurse operates is extensive enough for the roles and functions of a given position, up to date, within the law and directed towards client benefit. This provides a series of safeguards, enhances risk management and contributes to quality improvement through promoting application of the principles of ethics, which include doing good/not doing harm, justice and autonomy. For graduates, it can also lead to them questioning the adequacy of their preparation for practice and their ability to connect clinical and theoretical knowledge. As experienced nurses, it is important to reassure graduates of acceptance of them as knowledge-ABLE and, as such, well prepared for their future.

Over decades, much has been written about the impact of a purported reality shock that students experience during clinical experience and/or upon entry into the workforce as a graduate. The transition period from graduate to practitioner has been seen as a time during which nurses are socialised into the workplace and its formal and informal rules, protocols, norms and expectations. It has been identified as an exciting, challenging and stressful period (Walker et al 2017) for student and graduate nurses around the world (He et al 2018, Labrague et al 2018). A range of factors contribute to a sense of reality shock, including the need to adjust to the demands of shift work, time pressures associated with assuming a caseload, coping with workplace staff shortages, experiencing potential intergenerational differences in work values and ethics, and the need to accept accountability for patient safety and to delegate to and supervise other staff (Hawkins et al 2018). The transition from student to graduate has been identified as a period whereby the graduate initially focuses (we would say rightly) on themselves and their own development for at least the first six months in the workplace. The aspirations of the profession of nursing are for the transition period to be positive and supportive. However, despite these aspirations, new graduates continue to experience fragmentation and frustration as clinical demands conflict with access to support, mentorship and continuing development (Hawkins et al 2018).

There is a need to focus on the positive rather than the negative aspects of transition and to acknowledge the extent to which graduates have a repertoire of portable knowledge and skills which provide a foundation for the development of social identity as a nurse rather than as a student nurse in order to further the development of individual practice. Knowledge-ABILITY, through continuing development of self-insight, promotes a sense of self-efficacy and recognition of the need for self-

determination. It is associated with moving beyond the initial and natural sense of alienation experienced in an unfamiliar context to a sense of self-confidence, composure and resilience. This is an iterative rather than lineal process that requires that nurses take responsibility for themselves and their learning. This self-agency requires an ability to create meaning in a given context and to embrace a view of learning as 'volitional, curiosity-based, discovery-driven and mentor-assisted' (Janik 2005:144).

Connecting clinical and theoretical knowledge in 'classroom' learning

Substantial reference has already been made to the nature of reciprocity between clinical and theoretical knowledge and the importance of focused learning experiences related to nursing in either classroom or clinical settings. Through the design of the nursing curriculum, classroom learning provides opportunities to identify and apply theoretical knowledge, explore options and alternatives, justify thinking and learn from examples drawn from practice. It also gives students opportunities to develop the scholarly approaches necessary for contemporary nursing practice. Classroom learning experiences enable us to focus on our ability to acquire, recall and process theoretical knowledge from a range of sources, including other knowledge-ABLE people.

In our experience, it is essential that student nurses are able to access, retrieve and use information from reputable sources to draw conclusions about implications of ideas for nursing practice and to communicate these in writing and other forms. Increasingly, nursing programs are integrating these skills into the core nursing program and instructing students in information literacy and writing skills in ways that support connecting theory and practice, in particular through the concepts of evidence-based practice and health informatics. Information literacy and fluency is required in both classroom and clinical settings and an important element of any health professional's practice (Rapchak et al 2018).

In the classroom setting, support in information literacy and academic writing skills is available to students. Generic assistance to students ranges from short courses to individual consultations to assist in essay writing, including analysing and interpreting questions, planning, structuring and writing essays, referencing and assistance with mathematics for drug calculations. Students also benefit from spending time with the librarian, learning how to use the library effectively in order to access resources and conduct literature searches.

While we encourage the use of these support services, we would caution students that they do not provide discipline-specific information (Jefferies et al 2018), nor do they necessarily develop the skills for health information literacy, including the ability to effectively use health informatics. That is to say, staff of these units can assist you in structuring your writing, ensure your grammar and punctuation are correct and inform you about referencing, but they cannot provide the ideas for your work because they do not 'think and act like nurses'. It is important that students seek assistance from lecturing and library staff who are aware of current issues and debates in nursing, to clarify questions and check their understanding of aspects of nursing. It is important

that, in addition to using technology to support their own learning and development, nurses are technologically proficient and able to use information systems within clinical settings for a range of purposes including client management and clinical research (NMBA 2016, Roberts & Williams 2017).

REFLECTION

Think about your current studies and a situation in which you needed to connect and use both clinical and theoretical knowledge.

Write a story or case study about this situation and, using the reflective questions provided at the end of the chapter, reflect on this learning.

Repeat this process at several points in your development as a student and graduate.

CONCLUSION

While there is increasing emphasis on the development of cognitive abilities in nursing, this should not lead to what has been labelled as a dichotomy between clinical skills and theoretical knowledge. Despite claims made by some authors that emphasis on theoretical knowledge in nursing results in a devaluing of clinical skills and, consequently, a devaluation of clinical practice, practical and theoretical nursing knowledge are inevitably and infinitely intertwined. Nursing practice and nursing education have increasingly recognised the need to integrate thinking and doing to create informed action. Discussion of the separation of thinking and doing does little to promote integration of on-campus and clinical learning activity. Students should view their learning to be nurses as occurring in two distinct yet interdependent contexts: the classroom and the clinical setting. Furthermore, they should use their experiences as students to develop foundational knowledge and skills for effective, confident and competent transition to employment.

The past few decades have provided evidence that there is a paradigm shift in education, which now views learning as the construction of meaning in context rather than what to learn and how to do things. Nurse education is about the ability—indeed flexibility—to examine situations, deconstruct them from a number of perspectives and reconstruct them around core concepts essential to nursing practice. When students engage in reflective practice in a manner that enacts individual agency, they are able to reinforce self-worth, retain confidence and self-esteem and expand knowledge and skills.

Contemporary nursing practice demands that clinicians question and justify decisions in context, and emphasise the ability to think about nursing, as well as the ability to perform nursing actions to best manage nursing situations. The challenge for students is to develop an integrated approach to practice, which values thoughtful, highly skilled and efficient action, and to continue with lifelong learning and professional development—that is, to be knowledge-ABLE rather than simply knowledgeable.

REFLECTIVE QUESTIONS

1. What principles can you identify that underpin your learning in classroom and clinical settings and how do these assist you?
2. How can you become more responsible and accountable for your own learning, including planning and evaluating your learning?
3. Who can assist you with meeting your needs particularly when confronted by novel or challenging situations?
4. What are the strengths you take as a learner and a student of nursing to future practice?
5. What strategies will you use to develop the resilience, confidence and competence for

knowledge-ABILITY in a changing healthcare context?

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CHAPTER 21: GLOBAL HEALTH AND NURSING

Michele Rumsey

KEY WORDS

Chief Nursing and Midwifery Officer; data revolution; education; globalisation; governance; human resources for health; people-centred care; regulation; sustainable; development; goals; universal health; coverage

LEARNING OBJECTIVES

After reading this chapter, readers should be able to:

- understand the context in which global and regional policies and strategies influence health system planning and leadership;
- understand the role of major United Nations agencies in influencing global health priorities and planning;
- understand the governance role of the Chief Nursing Officer or Chief Nursing and Midwifery Officer;
- understand the importance of global, regional and national human resources for health (HRH) inter-sectoral plans to achieve universal health coverage (UHC);
- understand the role that regulation, education, association and governance play in shaping health workforce policy.

INTRODUCTION

This chapter will describe the impact of global and regional policies on everyday nursing and healthcare outcomes. It will look at the ways policies are designed and investigate approaches to building an effective international nursing workforce, discussing how nursing leaders can influence decision making at the highest levels. In addition, the importance of good governance and the role major international agencies such as the World Health Organization (WHO) play are explored. Throughout this discussion, the importance of maintaining accurate, up-to-date data on the capacity and skill-mix of the nursing and midwifery workforce will be highlighted.

Globalisation, which refers to the shrinkage of distance on a world scale through networks of connections—environmental and social as well as economic (Scholte 2008)—has brought the world to our cities, our towns and our homes. Information is exchanged in seconds, resources, goods and services are traded with fewer restrictions and people move between nations and borders with relative ease. The social changes accompanying globalisation have been enormous. A free flow of trade between higher-, middle- and lower-income countries has brought previously unaffordable goods to new markets, contributing to a change in diets, more sedentary lifestyles and increasing consumption of tobacco and alcohol.

Global trends such as urbanisation and the influence of Western lifestyles on middle- and lower-level countries has seen a shift in disease patterns. As a result, incidences of chronic, non-communicable diseases such as cancer and diabetes have escalated, with 38 million people dying each year, of which 85% are in developing countries (Stuckler 2008, WHO 2014, 2016b). For example, China has seen an increase in non-communicable diseases since the 1980s, which has been attributed to rapid economic growth, an increase in life expectancy and changes in lifestyle (Lowy Institute for Foreign Aid 2019a, Yang et al 2010). In response, China has undergone major health reforms, including the implementation of a universal health insurance scheme since 2009. A large-scale study in China has shown a decrease in deaths, including non-communicable disease-related deaths, since 2009, concluding that universal access to healthcare can have a major impact (Astell-Burt et al 2015). The Lancet Commission's report on Global Health 2035 (Jamison et al 2013) projected an increase of non-communicable diseases due to globalisation and increase in life expectancy. This report also advocates for universal health coverage as a way of combating the change and rise in disease patterns.

Due to huge international demand, healthcare professionals often leave their communities to pursue opportunities abroad and the trend towards urbanisation leaves many regional and remote communities severely underserviced. Health professionals who migrate nationally, regionally and globally must learn new cultural values and education systems (Morin 2012). They may have language issues and not understand culturally specific care demanded in the context of their new country (Rumsey 2019, Rumsey et al 2016).

Migration also contributes to a dearth of skilled practitioners in low- to middle-

income countries where they are needed the most (Buchan et al 2011).

In recent years, there has been a global push to foster health systems that are more attuned and responsive to the needs of the community, recognising that patients are people first. Health policy makers are embracing more holistic approaches to community wellbeing and moving away from doctor-dominated, bio-medical models of care (UN 2019). Nurses and midwives, so often on the frontlines of community engagement, are key to the provision and promotion of people-centred care (UN 2019, WHO 2017c). As such, the nursing and midwifery professions require leaders and advocates who can speak on behalf of their patients, influencing health policies, processes and nursing education programs. This influence can and should extend beyond national borders through Ministers and Ministries of Health to international policy making through the World Health Assembly (WHA) (White 2010). It takes governance, association, regulation and education to develop and sustain a strong, flexible and motivated health workforce (WHO 2016b). Effective leadership and strategic planning is only possible once these areas are integrated within a health system (Daly et al 2015) (see Fig. 21.1).

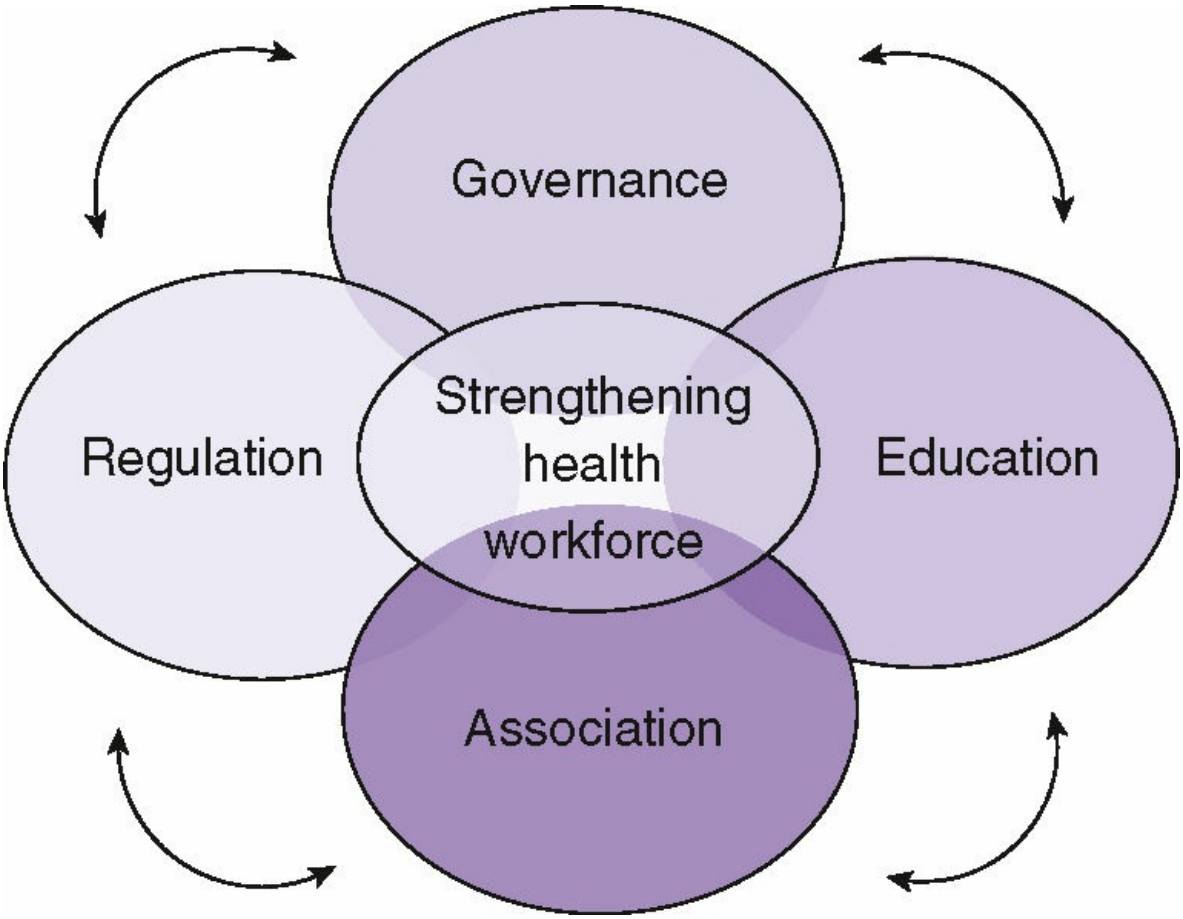

FIGURE 21.1 Integrated approach leadership for strategic health workforce planning

How global health strategies and policies are developed

The World Health Organization (WHO) is the Geneva-based United Nations (UN) agency charged with overseeing the UN's involvement in global health agendas. It has 194 member states located across six regions: Africa, the Americas, Europe, South East Asia, the Western Pacific and the Eastern Mediterranean (WHO 2019a). Each of the six regions has a main regional office and several country offices. The WHA is the decision-making body of WHO and the delegates from all WHO member states, as well as health professionals, non-government organisations (NGOs) and other UN agencies gather in Geneva every May at a political forum to discuss responses to emerging global health agendas. Programs and policies are proposed through 'resolutions', which have already been through a complex process of assessment by individual countries and discussed at the WHO WHA annual Executive Board Meeting in January. Resolutions cover many areas including epidemics, pandemics, natural and emergency disasters, chronic and acute medical issues, health workforce, universal health coverage (UHC) and WHO finances. Negotiations are conducted in side meetings between country representatives, often in regional groups, as they lobby for resolutions or amendments to resolutions. Collaborations between alliances often form and presentations are made to sway arguments for or against a resolution. Resolutions are then debated at the WHA under strict speaker time limits and are finally passed (with or without amendments) to formulate a WHO agenda of work for the next few years (General Program of Work 13 GPW13) (WHO 2019c).

Medical practitioners dominate representation of health professionals both within the ranks of WHO and amongst those debating at the WHA (WHO 2019c). This is a cause for concern among other stakeholder groups, including nurses and midwives, who recognise that other health professionals' points-of-view risk being ignored. In 2011, the International Council of Nurses (ICN) reported that from 2001, the percentage of nurses at WHO had slipped from 2.6% of professional staff to 0.7% and the position of Chief Nurse Scientist had been vacant since 2009; however, significant lobbying saw the WHO Director General appoint a Chief Nurse at the end of 2017. The ICN argues that in almost all countries nursing and midwifery services are estimated to comprise over 80% of all healthcare services (ICN 2012, WHO 2008), with over 50% of the health workforce being nurses and midwives (WHO 2016b) and in the Pacific, 78% (WHO 2017a). Nurses and midwives require high-level leadership and advocates to engage in health policy making and planning both in their own countries and internationally (UN 2019, WHO 2019c, g). Appointing a Chief Nursing Officer (CNO) or a Chief Nursing and Midwifery Officer (CNMO) is therefore a critical step for governments to ensure their own nursing and midwifery workforce is being represented at the highest level both at home and in a global context (WHO 2019b, f).

UNIVERSAL HEALTH COVERAGE

The concept of Primary Health Care (PHC) emerged in 1978 when the Alma-Ata Declaration affirmed access to health services as a basic human right (WHO 1978). In 2012, the concept of PHC was expanded through a United Nations resolution to

'Universal Health Coverage' (UHC) (Rockefeller Foundation et al 2014, United Nations 2012). WHO defines the goal of UHC as being 'to ensure that all people obtain the health services they need without suffering financial hardship when paying for them' (WHO 2019g). Achieving UHC and equitable health facilities for all requires strong, efficient health systems, access to funds to finance those systems, access to essential inputs such as medicines and technologies and access to a skilled health workforce of physicians, nurses and other workers (WHO 2019g). Countries are at different stages of attaining UHC. Proposed changes to Australia's Medicare system threaten its excellent track record on attaining UHC (Laba et al 2015), while attempts to reform the notoriously inequitable healthcare system in the United States continue to meet with political resistance. Conversely, small island states in the Pacific have been consistently striving for PHC since the Alma Ata declaration. Over the last two decades, a number of regional declarations and agreements promoting 'healthy islands' have repeatedly expounded the principles of PHC and UHC in the South Pacific (WHO 2016d).

In 2018 the UN stepped up the campaign to work on the first-ever political declaration on Universal Health Coverage: 'UHC: Moving together to provide a healthier world'. The campaign focused on Ask 1) Ensuring political leadership beyond health, Ask 2) Leaving no one behind, Ask 3) Regulation and legislation, Ask 4) Upholding quality of care, Ask 5) Investing more, investing better, Ask 6) Moving together (UN 2019). The 2019 document, 'Moving together to build a healthier world: Key Asks from the UHC movement, UN high level meeting on UHC', makes a strong case to political leaders to legislate, invest and collaborate with all societies to make UHC a reality. It states that everyone from everywhere should have access to quality and affordable health services. One clear focus has been Ask 4 'Upholding quality of care', and to 'Train a health workforce based on quality and competence, with a special focus on nurses, midwives and community health workers. Education must improve overall management capacity and skills and foster the appropriate use of technology. UHC requires supportive education policies, labor market regulations, effective environmental stewardship and monetary and non-monetary incentives for health workers' (UN 2019, WHO 2019g).

THE SUSTAINABLE DEVELOPMENT GOALS (SDGS)

The ability of governments to improve healthcare outcomes for their citizens is highly dependent on their healthcare workforce. Ensuring its ranks are populated with the right people has driven global policy makers since the launch of the United Nations' Millennium Development Goals (MDGs) in 2000. Agreement on the MDGs was a milestone for world leaders as this was the first time they had really come together to articulate a set of development targets. Their vision galvanised the global health community into new, high-profile partnerships. Initiatives such as the Global Fund to Fight AIDS, TB and Malaria, Stop TB, Roll Back Malaria, the Presidential Emergency Plan for AIDS Relief, and the Global Alliance for Vaccines and Immunisation attracted huge international funds (Travis et al 2004). Yet it soon became clear that a focus on disease eradication without strengthening national health systems and increasing personnel would be a temporary solution at best. In 2004, the High Level Forum on

Millennium Development Goals reported 'there is a human resources crisis in health which must urgently be addressed' (Travis et al 2004). The inability of many low- and middle-income countries to achieve the MDGs related to health—reducing child mortality, improving maternal health and eradicating malaria and HIV—was in many cases directly linked to insufficient and under-skilled health workers (WHO 2006).

The simplicity of the MDGs made them attractive to donors but the narrow focus of each goal meant that funds, advocates and experts became clustered in so-called 'MDG silos'. Detractors argued that failure to achieve MDGs related to maternal and child health was partly because their attainment depended on cross-cutting factors such as access to education (Sridhar et al 2013). Nonetheless, there were positive outcomes. The drive to meet the MDGs encouraged governments and international actors to 'measure what we treasure' and improve methods of obtaining baseline data for planning purposes. The importance of collecting data to better inform development efforts has had far-reaching implications (UN 2015). In the health sector, some alarming statistics emerged. For example, The World Health Report 2016—Global Strategy on Human Resources for Health: Workforce 2030 identified a 'global health workforce crisis', revealing an estimated shortage of over 18 million health workers worldwide to achieve sustainable development goals (SDGs), with a shortage of 2.4 million in the Western Pacific region alone (WHO 2016b, 2019h). The shortages were deemed particularly severe in developing countries and ambitious proposals to tackle the shortages were laid out in a 10-year action plan (WHO 2006).

Coupled with significant technological advancements in the first decade of the twenty-first century, monitoring for the MDGs spurred investment in data collection. Reams of statistics were recorded, geospatial information was plotted, forms were filled in and surveys were conducted but too many of these initiatives lacked capacity, understanding of needs and strong leadership. Much of the data recorded for the MDGs was not used to its full potential and not always translated into strong policy planning (Rumsey & Neill 2012, 2014). To achieve these goals and strategies, continuing professional development and contextualising of leadership programs for nurses and midwives were cited as crucial to manage services and utilise data (Asante et al 2012, Britnell 2019, Rhodes & Rumsey 2016, Rumsey et al 2017a, b, WHO 2016a).

In acknowledging the failings of certain health-related MDGs, policy makers sought to embrace more 'holistic' approaches to development. A 2012 WHO discussion paper noted: 'There is now greater recognition of the need to focus on means as well as ends; health as a human right; health equity; equality of opportunity; global agreements that enhance health security; stronger and more resilient health systems' (WHO 2012a). This more holistic approach has come to fruition. In January 2016, the SDGs came into effect, addressing the issues of silos and highlighting a specific target for UHC (UN 2019).

While the MDGs consisted of eight goals, there are now 17 SDGs to be measured against 169 targets. The SDGs are far more comprehensive in scope than the MDGs and each goal was crafted through extensive consultations between policy makers, civil society and the public (Sustainable Development Goals Fund 2019). Goal 3 aims to 'Attain healthy lives and well-being for all at all ages' and comprises nine quantitative and four qualitative targets. Within this goal, the original three health-related MDGs on

child and maternal health have been replaced by three even more ambitious indicators:

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

2. By 2030, end preventable deaths of newborns and children under 5 years of age.

3. By 2030, ensure universal access to sexual and reproductive healthcare services (Sustainable Development Goals Fund 2019).

To achieve these main goals, WHO developed its first-ever investment case of US$14.14 billion for 2019–2023, with a more media-friendly approach to seek funding and buy-in from global partners and countries. To deliver on a five-year strategy and its ambitious Triple Billion target: the targets in Fig. 21.2 show that the WHO will work towards providing a billion more people with UHC, protect a billion more people from health emergencies and bring a further billion people better health and wellbeing (WHO 2019e). WHO also developed many other new structures and global and regional operating shifts (WHO 2019h) to address these many strategies, including the National Health Accounts and health workforce tools (WHO 2017b) in an aim to align the WHO's processes and structures with the 'triple billion' targets and the SDGs by headquarters, regional offices and country offices, and eliminate duplication and fragmentation.

FIGURE 21.2 WHO driving delivery and measuring impact in Triple Billion targets (WHO 2019e)

There has also been a shift from the linear 'donor to beneficiary' model to promoting mutual accountability between the traditionally wealthy countries of the 'north' and the middle- and lower-income countries of the 'south'. China and India (Lowy Institute for Foreign Aid 2019b) are now two of the world's most powerful donors. Interwoven throughout the SDGs is a concentration on the world's ecology. Taking action against climate change requires a collective effort among all countries, no matter what their economic situation. Preservation of the world's ecology is considered fundamental for the wellbeing of communities everywhere with environmental degradation one of the biggest threats to economies and global security (van der Heijden 2016).

Measuring progress against the SDGs and triple billion targets will be a huge challenge, but innovations in technology and approaches over the past decade have led to more nuanced methods of data collection and interpretation. In August 2014, United Nations Secretary Ban Ki-moon asked an Independent Advisory Group to investigate the potential for a 'data revolution' in sustainable development. Key recommendations

included encouraging 'owners' of data to make it publicly available and increasing data literacy so that more people are able to use and interpret the information (Revolution 2014). Some commentators warn that promoting the SDGs will be complex and that some of the goals appear to be more aspirational than attainable, while others simply cannot be achieved in the proposed timeframe; that is, by 2030 (Hill et al 2015). Clearly, poverty is not a simple problem and its complexities necessitate a multi-faceted, integrated and holistic response (Sustainable Development Goals Fund 2019, WHO 2019d). SDGs advocates insist the vast amounts of stakeholder consultation that informed their creation will raise the stakes of the global community's investment. Lessons will be learned along the way and no doubt 2030 will see the evolution of another approach. Today the SDGs, UHC and Triple Billion (WHO 2019e) represent an enormous step forward and a continuation of a global approach to human rights, poverty alleviation, stability, security and economic empowerment (see Figs 21.2 and 21.3).

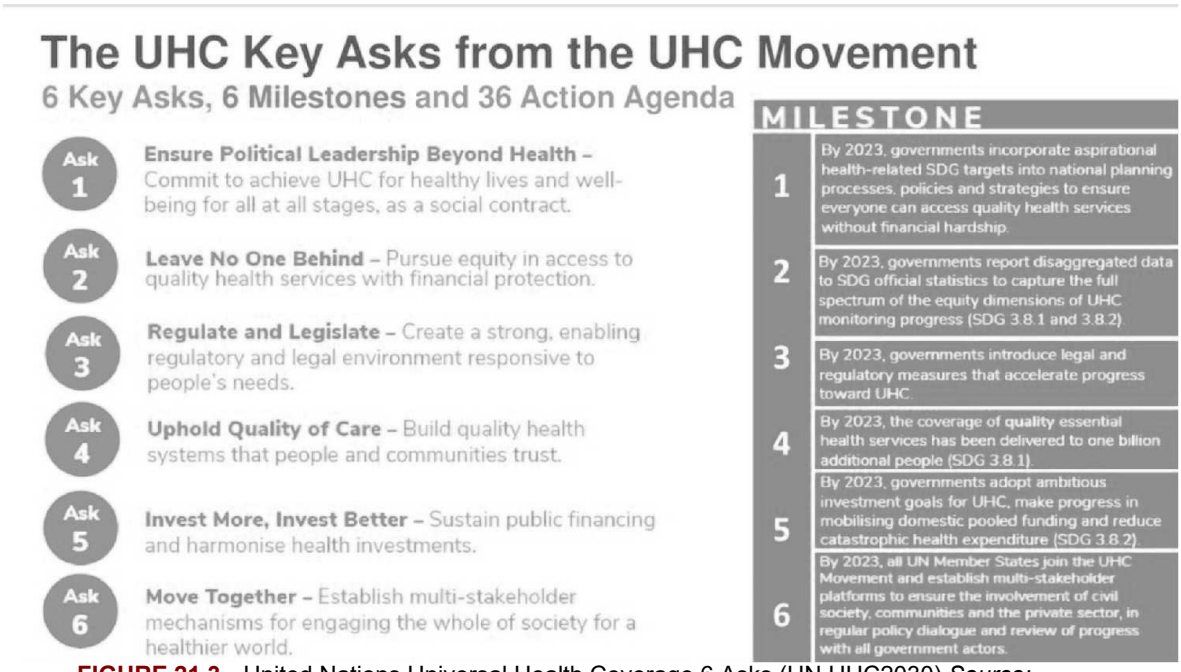

FIGURE 21.3 United Nations Universal Health Coverage 6 Asks (UN UHC2030) *Source:* https://slideplayer.com/slide/17238754/

REFLECTION

How do United Nations agencies influence global health priorities and planning?

Health policy at a country and regional level

So how do these global development and health agendas, goals, strategies and resolutions filter down to regions and individual governments? And how do regions and individual countries promote their own health priorities to decision makers when

global health agendas are being set?

The WHO has six regional offices that work semi-autonomously from headquarters in Geneva with their own budgets. The regional offices and country offices liaise and coordinate with local health ministers, NGOs and other partners to advocate for public health issues relevant to their corner of the world. For example, Australia and New Zealand fit into the Western Pacific Regional Office which works in 37 countries in an area stretching from China to New Zealand and covers a population of 1.8 billion people. It has its headquarters in the Philippines and another 15 country offices in various cities (WHO 2019h). This is further broken up into subsections, where Australia and New Zealand sit within the South Pacific region. The WHO representative for the South Pacific is based in Suva, Fiji, and leads the coordination of forums such as the biennial Pacific Health Ministers Forum where the relevance and impact of global policies to the region are debated and development funds are allocated to country and regional, bilateral or multilateral priority work (WHO 2012b, 2019h). Local issues are also discussed and this influences what Western Pacific representatives choose to highlight at the WHA. For example, at the 2013 Pacific Health Ministers Meeting in Samoa, a formal recommendation to 'Promote increased involvement of nursing in national and regional health governance structures' was made to strengthen health workforce in the region (WHO 2013a). This aligns with the UN UHC 2030 Key Asks campaign (UN 2019) (see Figs 21.2 and 21.3). Governments can achieve this by appointing a Chief Nursing Officer or Chief Nursing and Midwifery Officer (CNMO). To date, all countries in the South Pacific have a Chief Nursing and/or Midwifery Officer position, except Papua New Guinea (PNG). Within the 37 Western Pacific regional countries, 27 have a CNMO (Rumsey & Neill 2018), and some countries (such as Korea, the Philippines, Papua New Guinea, China and Mongolia) are working towards one in time for International Year of the Nurse and Midwife 2020 celebrations (WHO 2019b, f).

There are other regular development and health forums in the Western Pacific region including (but not limited to) the Pacific Islands Forum, the Small Island Developing States Conference, the Pacific Society for Reproductive Health, Pacific Community, and the Pacific Heads of Health Meetings. Regional forums specific to nurses include regular meetings of the Asia Pacific Emergency and Disaster Nursing Network and the South Pacific Chief Nursing and Midwifery Officers' Alliance. While the WHO is considered the peak international health body in most regions for health, the World Bank also implements regional health programs, as does the Asian Development Bank (in the Western Pacific) and its equivalent in other regions (such as the African Development Bank) as well as individual countries' aid programs. The Ministry of Foreign Affairs and Trade in New Zealand delivers the aid program for that country. AusAID was an autonomous Australian Government agency that implemented Australia's aid program for 30 years, but was absorbed into the Department of Foreign Affairs and Trade in 2013. Despite the integration and associated cuts to its foreign aid budget, Australia, although at an all-time low for aid spending, is still by far the largest donor in the Pacific Islands region (Lowy Institute for Foreign Aid 2019b). A host of other philanthropic agencies active in the health sector include the Bill and Melinda

Gates Foundation, Jhpiego (an affiliate of the Johns Hopkins University), Volant Charitable Trust and the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisations). The Asian Infrastructure Investment Bank (AIIB), coordinated by China with a start budget of $50 billion in 2014, has opened the door to new players in the development field, challenging many preconceived ideas about donors and development actors (The Economist 2014). This has engaged Australia to set up a Pacific Office to step up its approach to the Pacific in 2019–2020 for $1.4 billion in regional infrastructure grants (DFAT 2019). The concept of 'corporate social responsibility' has also encouraged the private sector to play a more active role in local health programs in some countries. For example, mining and extractive companies in Papua New Guinea, such as Rio Tinto and Oil Search, have partnered with the PNG Government and other donors to fund and deliver a range of health services (Thiessen et al 2018).

Current global and regional priorities in the health sector

HUMAN RESOURCES FOR HEALTH

Shortly after the WHO's Health Report of 2006 revealed a critical shortage of health workers, the Global Health Workforce Alliance (GHWA) was created to lobby political support to address the issue. A partnership between national governments, civil society, international agencies, finance institutions, researchers and educators, the GHWA has worked with other bodies such as the International Council of Nurses, to elevate human resources for health (HRH) on various global agendas and in the WHO's mandated program of work (Campbell et al 2013).

The above work led to the WHO's development of the global health workforce strategy 2030, which recommends that 45 doctors, nurses and midwives per 10,000 people will be needed to meet population needs by 2030 (Buchan et al 2017, WHO 2016d). An estimated 18 million more health workers, primarily in low-resource settings, will be needed to attain high and effective coverage to ensure healthy lives for all by 2030 (Rumsey & Thiessen 2018, WHO 2016d). Many countries are a long way from this target; for example, Papua New Guinea, Australia's closest neighbour, is currently in the midst of a health workforce crisis, with a ratio of only six doctors, nurses and midwives per 10,000 (Rhodes & Rumsey 2016, World Bank 2011). The data from the Global Burden of Disease study also shows Australia ranks 10th in relation to SDG health indices, while PNG ranks 155th out of 188 countries (based on performance of the health-related SDG index, and 33 individual health-related indicators, by country, 2015) (Lim et al 2016). A UN High-Level Commission on Health Employment and Economic Growth explored the challenges of assisting health practitioners to achieve the SDGs (Rumsey & Thiessen 2018) and new evidence highlights significant opportunities to generate and contribute to employment and boost economies in countries where decent jobs are most needed (Buchan et al 2017). In a global health sector where two-thirds of the employees are women, the health sector also has a significant role to play in relation to women's economic empowerment, providing equitable and effective policy, planning, management and governance to maintain the motivation of the health workforce (Buchan et al 2017).

The approved UN declaration in 2019 by 192 countries on UHC states that recognising there is a global shortfall of 18 million health workers primarily in low–middle-income countries, there is a need to build and retain skilled nurses, midwives and community health workers to ensure a strong and resilient health workforce (UN 2019).

Effective HRH planning and policies require solid, accurate HRH data (WHO 2015a). It is important to know where the health workers are, where they are most needed and where they are moving to and from. Understanding these patterns allows hospitals, rural services and clinics as well as health and education ministries to pre-empt staffing requirements. Knowing where the gaps and weaknesses are means knowing when and where to direct extra resources (Buchan & Rumsey 2008). The HRH Minimum Data Set (MDS) template (WHO 2015a) was developed between WHO and its regional partners as a tool to enable a rapid assessment of the nursing and midwifery workforce. It consists of a core set of standard indicators which are used, generally, at a national level for reporting on key aspects of health system delivery, including current workforce/staffing resources and future HRH needs. Its approach clearly outlined the need for multi-sectorial stakeholder meetings and collaboration to enable accurate HRH planning. This approach needs strong leadership to enable discussions with many stakeholders. The MDS also discussed the value of using regulation data in developing countries where historically HRH data has been sporadically captured. Following approval of the WHO Health Workforce Strategy 2030 the WHA, in its resolution 69.19, 'Urges all Member States to […] progressively implement the National Health Workforce Accounts' (WHO 2016d, 2017b). The WHO developed National Health Workforce Accounts (NHWA) (WHO 2017b) to facilitate the standardisation of a health workforce information system in order to improve data quality, as well as to support tracking HRH policy performance towards UHC and SDGs (WHO 2017b).

The nursing and midwifery workforce requires purpose-trained HRH managers and planners who are able to record and interpret this type of data and use the above tools. Access to more HRH data and high levels of 'data literacy' will allow planners to track trends in the labour market more effectively and respond with appropriate policies (WHO 2016d). In the case of the WHO Western Pacific region, HRH interventions to address the shortages have focused on training more workers, retention strategies (increasing salaries, raising the retirement age) or recruiting from other organisations, sectors or countries (Buchan & Weller 2013). Recruiting and retaining health workers to service remote, sparsely populated areas is particularly challenging for planners. Achieving a balance between cost, access and effectiveness in such circumstances requires planners to have a clear picture of patterns of supply and demand (Buchan et al 2017).

State of the World's Nursing report data collection

The WHO 72nd WHA resolutions approved 2020 as the International Year of the Nurse and Midwife and this has led to the development of the first-ever State of the World's Nursing (SOWN) report instigated by the WHO, that will be launched also in 2020, prior to the 73rd WHA. The SOWN report will describe the nursing workforce in member states using the WHO NHWA (WHO 2017b) and some supplementary indicators. The process of data collection for the report will provide an important opportunity to discuss data and policy to strengthen the role of nurses and midwives in health service delivery and create an opportunity to progress reforms in their education and training to ensure competencies in the delivery of care at all levels of the health system, especially in primary healthcare.

Improving the performance of the health workforce is a vital component of HRH management and the SOWN report will add evidence to UHC decision making and policy development. Practitioners need to be flexible enough to perform to a high standard when delivering primary healthcare but also be able to perform under pressure in public health emergencies such as natural disasters and conflicts. Sudden health shocks in one part of the world can necessitate an influx of health workers from elsewhere. The importance of education and regulation standards that meet international criteria is critical in such situations.

Many high-income countries are not only struggling to provide care for their ageing population, much of their health workforce is also ageing (WHO 2019h). This is particularly the case in the nursing and midwifery workforce. More needs to be done to attract young graduates and help them plan a career in the profession. Managers and leaders need to ensure opportunities for leadership and CPD so that health workers can continue to expand their skill set, post-registration (Rumsey et al 2017b, Wong et al 2015). Other considerations such as financial incentives, inclusive decision making, utilisation of scope and opportunities for professional advancement contribute to job satisfaction and encourage retention of staff (Buchan et al 2017, Dieleman et al 2009). Again it is hoped that the data from the SOWN report will provide crucial evidence for some of these important considerations.

Ethical migration in line with the WHO code of practice on international recruitment

One of the major contributing factors to an inequitable distribution of health workers is the so-called 'brain drain' that sees talented and skilled personnel leave their own countries or communities to pursue better paying work opportunities elsewhere. The escalating shortage of health workers in some middle- to high-income nations is increasingly being met by recruiting foreign health workers, often from middle- to low-income countries. This can leave already vulnerable health systems in poorer countries even more vulnerable, particularly in times of medical emergency. To address this

concern, the World Health Assembly adopted WHA 63.16: Global Code of Practice on the International Recruitment of Health Personnel (WHO 2017c). The code encourages voluntary ethical principles and practices for international recruitment. Some argue that more needs to be done to stem the flow of nurses away from 'source' countries to 'destination' countries and there have even been calls for an international treaty enforcing legislation to address the issue (Delucas 2014); others note that the right of the individual to move from one country to another should be pre-eminent.

There can be positive aspects for the destination countries as well as the individuals emigrating to improve standards of living, or for professional development. Given the complex dynamics involved, managing migration requires a considered, collective response from both 'source' and 'destination' countries. Again, data collection and data literacy are crucial. Maintaining and interpreting data on migratory flows allows governments and policy makers to monitor trends and identify gaps. It is critical to know which countries may need more considered, pre-emptive measures to manage any damage to their health system being caused by loss of health professionals (Buchan et al 2017). Currently only 40% of all countries signed up to the WHO Code (WHO 2019e) have introduced or are developing national laws and policies consistent with the WHO Health Worker Migration Code.

REFLECTION

Describe and critically reflect on how global and regional policies and strategies influence health system planning and leadership.

How nursing leaders influence global health planning

Given the fundamental role nurses and midwives play in delivering people-centred health services, it is important their voices are heard in forums discussing global and regional health priorities. A recent review of WHO documents highlighted common themes in issues faced by the global nursing and midwifery community as management and leadership, practice, education and research. The most pressing issue was found to be associated with the nursing workforce—not only its lack of numbers but also the need for better planning. The review concluded that nursing leaders need to 'think globally', sharing their expertise to stimulate learning amongst each other (Wong et al 2015). The WHO Collaborating Centre for Nursing and Midwifery at the University of Technology, Sydney (WHO CC UTS) has adapted a model to identify four essential elements necessary in the leadership approach to building collaborative health workforce policy (see Fig. 21.1). They are: (i) governance; (ii) association; (iii) regulation; and (iv) education. Any policy initiative seeking to improve the nursing and midwifery workforce should be based on the integration of these four stand-alone yet interdependent areas. Many of these areas are covered in detail and discussed widely in the WHO document 'Health employment and economic growth: an evidence base' (Buchan et al 2017).

GOVERNANCE

At the national level, governance of the nursing workforce is generally the

responsibility of a country's Department of Health. However, other departments also have a major stake in the governance of an effective health workforce. Given the importance of nursing education standards and accreditation, the Ministry of Education has an important role to play and the Ministry of Immigration will consider matters of international recruitment and out-migration. The Chief Nursing Officer (CNO) or Chief Nursing and Midwifery Officer (CNMO) (see Box 21.1) conducts information relevant to nurses and midwives both 'up' and 'down' the lines of decision making across all sectors and ministries. She or he can articulate the concerns of the population from the nurses and midwives to policy makers, and present the plans of policy makers back to the workforce. More importantly, they require negotiating and presentation skills to allow them to build effective networks within their own country's Ministry of Health, national nursing associations, regulatory bodies and education institutes. The CNMO should have a direct line to their government's Minister for Health and/or the Health Secretary who is not always a health practitioner. The nursing community should support the CNMO by ensuring they have accurate data and information about their national health workforce and population health issues.

BOX 21.1 Role of the Chief Nursing and Midwifery Officer

- Advise on nursing and midwifery's contribution to meeting population health goals and development of national health plans
- Provide timely and accurate data-informed advice in relation to nursing and midwifery workforce, workforce capacity and skill-mix (including the maintenance of a minimum data set which is internationally comparable)
- Oversee crisis response and emergency preparedness, planning and implementation
- Professional regulation and policy in relation to nursing and midwifery and their inter-professional intersections
- Service/care delivery quality, standards and patient safety
- Inter-sectoral liaison, collaboration and networking
- Educational program standards, accreditation and funding

Source: White 2010.

The CNMO also advises the government on matters related to nursing and midwifery such as the development and review of standards for primary care and midwifery, and promoting nursing as a career of choice. Implementing and evaluating strategic health

policy, reshaping health services and systems, and overseeing programs addressing specific health problems are important functions of the role (White 2009, WHO 2015b). The South Pacific Chief Nursing Midwifery Officers Alliance (SPCNMOA) is an alliance between CNMOs in 14 Pacific Island nations including New Zealand and Australia. New Zealand was the first country in the world to have a CNO, Elizabeth Grace Neil, who played an instrumental role in drafting the country's (and the world's) first Nurses Registration Act of 1901 (Hughes 2002). In contrast, Australia has had years without a national leader. Rosemary Bryant was appointed CNMO in 2008–2015, after 25 years of lobbying by nursing and midwifery groups for such a role to be instated. The appointment of a national CNMO means that Australia can now participate in WHO's CNMO meetings at the WHA (White 2009). The WHO Director General Dr Tedros Ghebreyesus reintroduced the position of WHO Chief Nurse in 2017 with the appointment of Mrs Liz Iro. Mrs Iro has led the many changes we see today with the State of the World's Nursing Report and International Year of the Nurse and the Midwife (Rumsey & Thiessen 2018' Salvage & White 2019). Early findings of research being carried out in this area (Rumsey 2019) suggest that if leadership programs are contextualised to country and health practitioner needs, positive career development changes can be obtained. This was the case for 85% of participants of a program run at WHO CC UTS (Rumsey et al 2017), with nine CNMOs self-funding to attend the World Health Assembly and two participants rising to the position of Minister for Health in their respective countries.

REFLECTION

Discuss the support role that nurses and nursing organisations can provide to the CNO or CNMO.

ASSOCIATIONS

Professional associations, alliances and unions support the nursing and midwifery workforce and play an important role in influencing power brokers in the health sector. Countries without strong nursing/midwifery associations lack a platform for issues affecting them to be identified and considered at higher levels. Associations are one of the stakeholders that inform the CNMO's decision-making process when advising the Health Minister. Having access to nursing industry information ensures any Health Minister taking part in the WHA decision-making process will have a broad perspective on the health workforce issues, and one that is not limited to the needs of medical practitioners. International professional nursing and midwifery associations include the International Council of Nurses (ICN) and the International Confederation for Midwives (ICM). These groups provide regular forums for nursing and midwifery leaders to connect and engage with policy makers. They advocate for the nursing and midwifery professions and some provide opportunities for CPD for their members. Research carried out in the Western Pacific region (excluding Australia and New Zealand) has shown that many nurses report that CPD opportunities are extremely limited, with many never having received any professional development since registration (Rumsey et al 2017b). Not all countries have strong professional

associations, and this results in a lack of involvement of nurses and midwives at health policy levels. Conversely, often many nurses and midwives do not recognise the value of being involved in a professional association and the added value it can bring to their career development.

Regulation

Professional regulation creates 'a framework that maintains the justified confidence of patients in those who care for them as the bedrock of safe and effective clinical practice and the foundation for effective relationships between patients and health professionals' (UK Government 2007).

Globalisation and increased migration of nurses has increased the need for internationally compatible standards of accreditation. Regulation of health professionals is fundamental to protecting and maintaining the health and safety of the public. There are four recognised elements of regulation: (i) registration; (ii) standard setting; (iii) accreditation and management of conduct; and (iv) performance and impairment matters (Chiarella & White 2013). Nurses should be educated to a certain standard and the quality of their work maintained throughout their career by attaining further qualifications with CPD, and Codes of Ethics and Conduct ensure standards are maintained in clinical practice. Regulation has been a priority of the ICN for many years. The ICN and WHO regularly host 'Triad' meetings in partnership with ICM where representatives from national nursing and midwifery regulatory bodies discuss regulation issues as well as governance and association. The ICN has published a number of guidelines on regulation and resources (ICN 2019). The ICM has released its Global Standards for Midwifery Regulation and developed a Midwifery Education Accreditation Programme (ICM MEAP) in response to requests to improve quality from midwives, midwifery associations, governments, UN agencies and other stakeholders (ICM 2011, Nove et al 2018).

Given the huge diversity in population health needs and legislative processes, 'principle-based' regulation is the approach favoured by the ICN to the development of international nursing regulatory guidelines. Advocates of principle-based regulation work towards regulation that is proportionate, consistent, targeted, transparent, accountable and agile. Principle-based regulation is, in other words, applied with the 'right touch' for the problem being tackled (Professional Standards Authority 2016), and is the minimum regulatory force required to achieve the desired result (Council for Healthcare Regulatory Excellence 2010). Right-touch regulatory processes are simple and solution-based and do not enforce prescriptive, arbitrary rules across the board, and should be reviewed regularly to gauge effectiveness and to check for any unintended consequences.

In Australia, the Australian Health Practitioner Regulation Agency (AHPRA) is the national regulatory body for all health professionals. It was created in 2010 following a Health Workforce Productivity Commission Report (2005) that stated there were over 90 authorities in health regulation in Australia. The Council of Australian Governments (COAG) agreed to streamline the system by establishing a single national registration scheme. AHPRA works with national professional boards representing different groups

of practitioners within the health sector (including the Nursing and Midwifery Board of Australia) to administer registration standards (Australian Health Practitioner Regulation Agency 2011). AHPRA is tackling the many multidisciplinary regulatory issues in Australia and internationally with the WHO. New Zealand has a national regulatory body for nurses through the Nursing Council of New Zealand and is one of the few countries with a separate council for midwives—the New Zealand Midwifery Council.

A review of regulation of the health workforce in the Western Pacific region found significant variation between countries in terms of the systems, approaches used and maturity of their respective regulatory systems. These differences include regulation that is government or professionally led that influences the institutional arrangements made, and whether other professions, the general public or community are involved. The report from this review clearly articulates that weak regulation can negatively affect access to health services and the efficiency and quality of health service provision. Ensuring equity of access to an appropriately trained and skilled health workforce to deliver safe, consistent and good-quality health services is therefore a priority in the Western Pacific region (WHO 2016c).

EDUCATION

The global drive for UHC demands a reliable, flexible, resilient and motivated workforce (WHO 2019g). Countries need well-trained nurses and midwives who are flexible enough to meet the specific needs of their communities on a daily basis, but are also ready to provide care in emergencies such as pandemics and natural disasters that are increasing due to climate change (Gero et al 2015). Preparing nurses and midwives to practise in international settings poses a huge challenge as education standards vary greatly from one country to another. In some countries, nurses need only to complete high school to Grade/Year 12 to apply for a diploma, while in others, a university education is mandatory (Morin 2012). In 2009, WHO released a set of *Global Standards for Initial Education of Professional Nurses and Midwives* intended to: 'serve as a benchmark for moving education and learning systems forward to produce a common competency-based outcome in an age of increasing globalisation' (WHO 2009). These standards stipulate that nursing education should take place in an institution of higher learning such as a university. Concrete and explicit definitions and standards around nursing education equip educators with a blueprint for curriculums that meet international requirements (Morin 2012). Although these global standards are now over 10 years old, many educational institutes within the region still fall short of meeting these standards. The benefits of definitions, standards and accreditation cannot be underestimated to inform quality education, policy and practice.

In 2013 WHO released its guidelines for 'Transforming and scaling up health professionals' education and training' with the objective of increasing 'the quantity, quality and relevance of health professionals, and in doing so strengthen the country's health systems and improve population health outcomes' (WHO 2013b). The guidelines called for new approaches in health professionals' education and a move away from the traditional focus on tertiary care hospitals, to initiatives fostering community

engagement.

Educating nurses and midwives to a high level of professionalism with opportunities for research, management and leadership is also important for improving career pathways, professional status and advancement. More highly educated nurses are needed to become educators, to oversee the development of education programs, to conduct research and, ultimately, to become leaders in and advocates for the profession (WHO 2013b).

These guidelines will require review following first baseline data provided by the WHO SOWN Report in 2020.

REFLECTION

How do regulation, education, association and governance effectively shape the provision of quality care to ensure patients' needs are met?

CONCLUSION

The contribution of nurses has never been more crucial (UN 2019). Populations continue to grow and age while patterns of disease fluctuate with a variety of factors including social changes brought on by economic and technological expansion. Health workforce shortages affect every corner of the globe, while urbanisation draws services and providers into the cities, leaving those on the margins and in remote and isolated settings ever more vulnerable.

As we know, nurses and midwives represent between 50% and 80% of the world's health workforce (ICN 2012, WHO 2008, 2016b, 2017c, 2019f) yet account for less than 5% of WHO's professional staff, the world's largest organisation with a focus on international public health. For the benefit of both their patients and their professional status, nurses and nursing leaders must step up and engage in health policy planning locally, nationally and globally. Nursing and midwifery leaders need to 'think globally and act locally'.

Improved data literacy, analysis and management can strengthen health system performance, quality and sustainability through the provision of knowledge required to inform practice, management and policy decision making. In Australia, for example, workforce planning data remains somewhat inconsistent and the local healthcare system continues to suffer from extremes in over-supply and under-supply of healthcare workers. Some acknowledgement of the difficulty caused by the lack of a national approach to this, may help the argument for the problem at a global level.

A renewed focus on UHC, and Triple Billion targets within the SDGs demands a flexible and resilient, highly educated and motivated workforce. The recognition of the nursing and midwifery workforce by WHO and the UN to achieve UHC brings with it both opportunities and challenges. Achieving UHC will only be possible if nurses' and midwives' full potential is recognised, and their full scope is utilised. Dominating the frontline of health service delivery, nurses and midwives have a social responsibility to report their experiences and outline their requirements all the way up to the WHA. To do this, appropriate channels of communication and empowered leaders are required. National governments must instate a CNO or CNMO to ensure that the experience of the workforce is appropriately considered in ministerial deliberations on health policy. Well-briefed ministers, armed with the right information, will enable senior leaders in health to voice their concerns and empower CNMOs to communicate with international policy makers at various global forums.

Leadership programs that are contextualised to country and regional needs and provide opportunities for succession planning, data literacy and policy development with a primary healthcare approach, are urgently required (Rumsey 2019, Rumsey & Neill 2018).

The role of professional networks in sharing information and stimulating learning is critical. It is important for nurses and midwives to access and support these networks by joining associations/societies, seeking out opportunities for CPD, contributing to debates and social media about regulatory and legislative issues, and supporting their

leaders with information and advice. Governance, regulation, association and education are the cornerstones of any health system. To advance the status of health professions in line with civil society's changing needs and to ensure best practice, the global nursing and midwifery community must shape itself around these key areas:

- Good **governance** ensures that issues affecting health populations are taken into consideration by ministerial policy makers. Equally, it ensures policies are relevant, communicated to and owned by the nursing and midwifery workforce. Empowered leaders such as CNOs and CNMOs are essential to promote policy dialogue across all the health sectors to ensure health governance.

- Strong professional **associations** (societies) provide information, information-sharing opportunities and advice to all health stakeholders. Associations also advocate for and support their nursing and midwifery members with advice and opportunities for CPD.

- **Regulation** ensures the protection of the public by developing, monitoring and maintaining standards to uphold quality of registrants, and requires up-to-date legislation, reliable registration processes (including data), competencies and codes. Accreditation of educational institutes and management of conduct are the cornerstones of a well-regulated workforce.

- Quality **education** requires highly qualified educators, opportunities for CPD, research, regular institutional accreditation, and access to quality curriculums and resources.

Finally, nurses and nursing leaders have an integral role to play in the data revolution that will ensure progress on the path to meeting health-related SDGs and UHC by 2030. Recording numbers on population health and workforce requirements is no longer adequate. Policy debates on health matters at the country, regional and global levels must be informed by high-quality, accurate data that is diverse, timely and internationally comparable. The nursing profession needs a new wave of 'data literate' nurses and leaders, trained in cutting-edge monitoring and evaluation methods. This will allow policy makers to make better decisions for people-centred care with a primary healthcare focus in partnership with civil society, nurses, midwives and other health professionals.

REFLECTIVE QUESTIONS

1. How can nurses/midwives and nursing/midwifery groups get involved in the development of global, regional and national inter-sectoral plans?

2. How would a nurse/midwife effectively integrate these plans into everyday practice?
3. How has the international development agenda evolved post 2000?
4. Why is data collection so important to planning for human resources for health?
5. How do international policy decisions have an impact at our local clinical or practice level?
6. What are the key responsibilities of a Chief Nursing and Midwifery Officer?
7. What are the principles behind right-touch regulation?

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GLOSSARY

Aboriginal and Torres Strait Islander Health Services; Aboriginal Medical Services: Services that may be established and governed (controlled) by Aboriginal and Torres Strait Islander peoples in their communities or in partnership with Aboriginal and Torres Strait Islander peoples specifically to improve access to health services for Aboriginal and Torres Strait Islander peoples.

acceptability: The test applied to a premise or reason. In order to have a sound argument, a premise must be acceptable to the person evaluating the argument.

accountability: Responsibility for one's own actions; this is a principle of professional practice that is obligatory for healthcare providers.

action: Anything done or performed; the process of doing something.

advocacy: Acting on behalf of, or in partnership with, a person and their family to ensure access to resources.

aesthetic: An abstract notion used in discussing the artistic aspect of nursing (and its creative expression). In this context, it relates broadly to theoretical and practical aspects of nursing art.

affective: Pertains to moods, feelings and attitudes.

agency: The ability of a person or community to act to exert or influence power.

altruism: Regard for others as a principle for action; unselfishness.

argument: A conclusion that is supported by a set of reasons intended to provide grounds for the acceptability of the conclusion.

art of nursing: Actions develop to create unique and deeply meaningful engagement with others that touch commonality of the human experience.

autonomy: Personal or political independence, self-determination, self-sufficiency.

binary: Composed of two parts. *See also* dichotomy.

bioethics: An interdisciplinary field of inquiry characterised by a systematic and critical examination of the moral dimensions of healthcare and other associated fields (e.g. the life sciences) from the standpoint of various ethical perspectives.

biologism: A particular form of essentialism (see below) in which women's (or men's) essence is defined in terms of their biological capacities.

caring: Compassionate or showing concern for others. Can refer to behaviour used by those who belong to a profession such as nursing that involves looking after people's physical, medical and general welfare.

clinical decision making: When making decisions, nurses draw from many sources,

including their formal nursing education and/or from their experience gained over time in practice.

clinical leadership: Leadership and management skills that nurses need to succeed in today's changing healthcare environment. A clinical nursing leader is one who is involved in direct patient care and who continuously improves the care that is afforded to such persons by influencing the treatment provision delivered by others.

clinical learning: Refers to the learning by which students have the opportunity to develop a wide range of skills through experience with patients and their problems. Its strengths are that it is highly relevant to future professional practice, integrates students into healthcare teams and provides role modelling by clinical teachers.

clinical management: Clinical management is the core of health services delivery—following best practice to deliver care and treatment to patients. As healthcare grows in complexity, as we move to models of care that are shared between clinicians, the challenges around access to information, decision processes and communication increase.

'close the gap': A campaign to reduce the gap in life expectancy, employment and educational opportunities between Aboriginal and Torres Strait Islander peoples and other Australians.

community assessment: A structured study of a specified community or targeted area that uses objective data to assess the current conditions and identify areas of strength and weakness.

community health: A major field of study within the nursing, medical and clinical sciences, which focuses on the maintenance, protection and improvement of the health status of population groups and communities as opposed to the health of individual patients.

community mental health: Community mental health is a decentralised pattern of mental health, mental health care, or other services for people with mental illnesses. Community-based care is designed to supplement and decrease the need for more-costly inpatient mental health care delivered in hospitals.

community nursing: A field of nursing that is a blend of primary healthcare and nursing practice with public health nursing. The community health nurse conducts a continuing and comprehensive practice that is preventive, curative and rehabilitative. The philosophy of care is based on the belief that care directed to the individual, the family and the group contributes to the healthcare of the population as a whole.

compassion: A core professional value of caring is compassion and an ability to respond with humanity and kindness to others' pain, distress, anxiety or needs. It is also the possession of knowledge of assessed needs to identify ways in which to develop empathy, to give comfort and relieve suffering.

congruency: Agreement or consistency in two or more views or positions. For example, in examining two or more theoretical views, one may find that there are areas of agreement across the same ground; hence, there is evidence of congruency.

construct: 'A type of highly abstract and complex concept whose reality base can only be inferred. Constructs are formed from multiple less abstract or more empirical concepts' (Chinn & Jacobs 1983:200).

critical friend: A trusted colleague who provides feedback on your work.

critical incident analysis: The use of clinical or personal incidents as a reflective tool.

critical thinking: To stop and reflect on the reasons for doing things the way they are done or for experiencing things the way they are by focusing on what is frequently taken for granted and evaluating the values, beliefs and assumptions that are held, and asking whether what is done and thought is justifiable or not.

cultural competence: 'A set of behaviours, attitudes and policies that come together in a system, agency or among professionals to enable that system, agency or group of professionals to work effectively in cross cultural situations' (National Health and Medical Research Council 2005).

cultural safety: A philosophy of healthcare specific to working in a cross-cultural situation with Indigenous peoples. It is achieved by personal reflection and understanding of your own culture before you can meaningfully interact with Indigenous people (Ramsden 2002).

curriculum: A set of courses constituting an area of study or specialisation.

decision making: The process of making a choice between a number of options and committing to a future course of action.

deductive reasoning: The process of inferring particulars from general laws or principles.

dialectic: Defined in the Australian Concise Oxford Dictionary (1987) as the 'art of investigating the truth of opinions, testing of truth by discussion [or] logical disputation or criticism dealing with metaphysical contradictions and their solutions; existence or action of opposing forces'.

dialectical: A process or perspective involving a dialectic. For example, in theory development using a dialectical approach to generation of knowledge, the process could involve debate with presentation of an argument (thesis), which is considered critically and challenged by a counterargument (antithesis), which is considered critically in relation to the thesis and other knowledge, possibly leading to new areas of agreement and understanding (synthesis).

dichotomy: The term can be used to indicate a divide between two theoretical positions, which are polarised or incompatible.

discourse: An abstract notion used to label a collection of ideas or theoretical perspectives within an academic discipline. This may be composed of theses or arguments representing knowledge in the discipline, including areas of agreement and disagreement, fundamental assumptions, values and beliefs, expressed in disciplinary language and symbols. The notion reflects the idea of a conversation using language within these boundaries.

dissemination: The act of distributing or spreading something, especially information, for it to become widespread.

diversity: A variety of something, such as opinion, colour or style; can refer to ethnic variety, as well as socioeconomic and gender variety, in a group, society or organisation.

early intervention: The initiation of supportive therapeutic strategies as soon as a problem or challenge is identified. Is often associated with disability and involves longer-term engagement.

emotional competence: Emotional competence in nursing is to become self-aware, develop regard for yourself and work on ways to manage your emotional reactions. This includes moving beyond your own needs and working with another person's issues or needs, including recognising and managing conflict.

empathy: The ability to connect with the life of another person and to accurately perceive their current feelings and their meaning. Empathy begins with putting your own concerns and needs aside and being open to the other person's perspective and experience.

empiricist/logical positivist model: An approach grounded in the belief that the world can be viewed as a machine and that the task of science is to discover the laws by which the machine operates; emphasis on predictability, measurement and the quantification of observable data.

engagement: The ability of nurses to connect with patients as unique people. The process of engagement is built over time and includes recognising people as social beings with a need to connect and share experiences with others in order to give meaning to their situation and create a working partnership.

epistemology: The theory of knowledge; the origins, nature, methods and limits of human knowledge.

essentialism: The attribution of a fixed essence to women; that there are given, universal characteristics of women, including biological, psychological and social characteristics, which are not readily amenable to change.

ethical principalism: The view that moral decisions are best guided by appealing to sound universal moral principles, such as the principles of autonomy, beneficence, nonmaleficence and justice; ethical principalism is one of the most popular approaches used to examine ethical issues in healthcare.

ethical professional conduct: 'Conduct that accords with and upholds the accepted ethical principles and standards of a given profession and which is thereby deemed to be "right" and "correct" ' (Johnstone 2016:4).

ethical universalism: The view that there exists one set of universal values/standards that is applicable to all people throughout space and time, regardless of their histories and/or cultural backgrounds (contexts).

ethics: A branch of philosophic inquiry concerned with understanding and examining

the moral life. It seeks rational clarification and justification of basic assumptions and beliefs that people hold about what constitutes right or wrong/good or bad conduct. Can also be defined as a system of action guiding rules and principles that function by specifying that certain types of conduct are required, prohibited or permitted. The term 'ethics/ethical' may be used interchangeably with the term 'morality/moral'.

etiquette: A set of behavioural action guides concerned with the maintenance of style and decorum in social settings; often, although mistakenly, confused with ethics/morality.

evaluation: A critical appraisal or assessment; a judgement of the value, worth, character or effectiveness of something; measurement of progress. The purpose of the evaluation is to determine whether outcome criteria have been met and how care for the patient might be improved.

evidence: Something that gives a sign or proof of the existence or truth of something, or that helps us to come to a particular conclusion.

evidence-based practice: The conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient; integrating individual clinical expertise with the best available external clinical evidence. EBP is the integration of clinical expertise, patient values and the best research evidence into the decision-making process for patient care.

feminisms: This term captures the variety of theoretical approaches to the support of equal rights for women, in all spheres of life, along with a commitment to improve the position of women in society; includes liberal feminism, socialist feminism, radical feminism, postmodern feminism and so on.

gender: A social construction that expresses the many areas of social life, as distinguished from biological sex; the socially learned behaviours and expectations that are associated with the two sexes.

generic: A characteristic that is 'general, not specific or special' (Australian Concise Oxford Dictionary 1987).

grounded theory: A research process designed to lead to generation of theory through study of a particular human situation or context.

grounds: The degree to which a set of reasons supports a conclusion.

habits of mind: The dispositions or inclinations of a thinker that influence the way in which a person uses or applies the cognitive skills of critical thinking.

health insecurity: The opposite of health security; the awareness of being (in)secure that health is good and if not there are ways to obtain care to return to good health. Whereas health security aims to guarantee a minimum protection from diseases and unhealthy lifestyles, there are no such guarantees in the case of health insecurity.

health literacy: The capacity to obtain, process and understand basic health information and services. A certain minimal degree of health literacy is necessary in order to make appropriate health decisions.

health policies: 'The strategies and courses of action adopted as being advantageous and expedient to provide within the resources available from a health system that at least maintains, and preferably improves, health' (Hennessy & Spurgeon 2000:6).

health promotion: 'Health promotion is a broad field of activity ranging from actions that are essentially medically focused and individual (such as individual risk-factor assessment and counselling) to actions aimed at helping people to change their behaviour, and further along to actions that seek to create supportive environments and settings that address a broad range of social and environmental determinants of health' (Marshall 2004:185).

hermeneutics: A process of interpretive analysis, which is concerned with uncovering meaning and a technique for interrogating text. Van Manen states that 'hermeneutics is the theory and practice of interpretation. The word derives from the Greek god Hermes whose task it was to communicate messages from Zeus and other gods to the ordinary mortals' (van Manen 1990:179). Hermeneutics was originally a technique used to interpret religious texts, which has made a transition into research activity in the social sciences and humanities. Hermeneutical refers to a process or perspective involving hermeneutics.

holism: A perspective in which people are seen as made up of biological, psychological, social and spiritual components, which are indivisible.

humanism: Suggested in nursing as a perspective on life that is centred on concern for human interests, meanings or values and safeguarding the person's dignity. Humanistic nursing is an experience lived between human beings, so nurses need to move beyond the technical *doing* of nursing, to become able to experience the feeling and *being* of nursing.

humanitarian concerns: Concerned with or seeking to promote human welfare; denoting an event or situation which causes or involves widespread human suffering, especially one which requires the large-scale provision of aid (English Oxford Living Dictionaries 2017).

hypotheses: Tentative statements of relationships between two or more variables, which have little empirical support. The repeated confirmation of hypotheses changes their status to empirical generalisations (statements with moderate empirical support) and thence to law (statements with overwhelming empirical support).

iconography: 'Illustration of subject by drawings or figures; book whose essence is pictures; treatise on pictures or statuary; study of portraits especially of an individual' (Australian Concise Oxford Dictionary 1987).

induction: The process of discovering a general principle from a set of facts.

inductive reasoning: The process of inference of a general law or principle from the observation of particular occurrences.

influence: The practice of expressing ideas and gaining support for those ideas and subsequent actions.

journalling: The technique of recording thoughts and feelings after reflecting on an event.

magnet hospitals: Hospitals that have particular quantifiable features, each of which is based on recognition of the contribution of nurses to patient care and the overall environment. These features include: 'effective and supportive leadership; nursing staff decision making; commitment to professional clinical nurse qualities; participatory management; autonomy and accountability, and a supportive environment' (Buchan 1999).

managed care: A health management system that controls the resources and delivery of services to people who are enrolled in a specific type of healthcare plan.

masculinist: Pertaining to the masculine; the male gender characteristics derived from social construction and expectation.

megatrends: Literally a major or 'big' (mega) trend or movement that has a lasting impact on society, cultures and people's lives; may also be defined as 'an important shift in the progress of a society or of any other particular field or activity; any major movement' (English Oxford Living Dictionaries 2017).

mental health care: State and territory governments fund and deliver public sector mental health services that provide specialist care for people with severe mental illness. These include specialised mental health care delivered in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services. In addition, states and territories provide other mental health-specific services in community settings such as supported accommodation and social housing programs.

mental illness: Refers to a wide range of mental health conditions/disorders that affect mood, thinking and behaviour. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours.

meta: A prefix commonly encountered in theoretical literature. In this context it means 'beyond or higher order' (Australian Concise Oxford Dictionary 1987). A meta-paradigm of any discipline is a statement or group of statements identifying the relevant phenomena to the discipline (Fawcett 1984).

model: A schematic representation of some aspect of reality, which may be empirical or theoretical. Empirical models are replicas of observed realities (e.g. a plastic model of the ear). Theoretical models represent the world in language or mathematical symbols (e.g. nursing's 'grand theories').

moral/morality: *See also* ethics.

moral duty: An act that a person is bound to carry out for moral reasons.

moral obligation: As above, an act that a person is obligated to perform for moral reasons; is generally regarded as being weaker than a moral duty and may be overridden by stronger moral duties.

moral principles: General standards of conduct that make up an ethical system of action guides and which carry particular imperatives (e.g. 'Do no harm').

moral right: A special interest that a person has and which ought to be protected for moral reasons (e.g. the right to life) (contrast with legal right; e.g. a special interest that a person has and which ought to be protected for legal reasons); moral rights generally entail correlative rights.

moral rules: Derived from principles and prescribed particular standards of conduct (e.g. 'Always tell the truth'). Rules have less scope than principles; they also do not have the same force and can be overridden by principles.

naturalism: A form of essentialism in which a fixed nature is assumed for women, not readily amenable to change.

nurse practitioner: A registered nurse who through advanced training is qualified to assume some of the duties and responsibilities formerly assumed only by a physician —abbreviation NP; also called a nurse clinician.

nursing ethics: The consideration of various ethical and bioethical issues from the standpoint of nursing theory and practice.

nursing roles: The role of the nurse refers to the main role (i.e. the core nursing role with the most number of hours) in the nurse's main job. Core nursing roles are divided into two main groups, clinical and non-clinical, with several categories in each group, such as registered or enrolled nurse, supervision and management. The non-clinical role may include education, research or industrial relations.

Occam's razor: The principle that the simplest explanation is most likely to be the right one.

organisational culture: The values and behaviours that contribute to the unique social and psychological environment of an organisation. Organisational culture includes an organisation's expectations, experiences, philosophy and values that hold it together, and is expressed in its self-image, inner workings, interactions with the outside world and future expectations. It is based on shared attitudes, beliefs, customs and written and unwritten rules that have been developed over time and are considered valid.

paradigm: A paradigm is a term used to describe accepted practices and techniques through which a discipline accumulates and refines its knowledge base.

patriarchy: The social system in which the masculine dominates, oppresses and exploits the feminine, within the spheres of reproduction, sexuality, work, culture and the state.

person-centred: A person-centred approach involves focusing on the elements of care, support and treatment that matter most to the patient, their family and carers. The priority is to identify what is most important to the person, without making assumptions. Person-centred nursing values the emotional and spiritual wellbeing of the person and reflects a person's values, relationships and need for self-expression.

phenomenology: A philosophy and descriptive research method designed to uncover the essence and meaning of lived experiences—for example, suffering or grieving (Parse 2001). In a phenomenological research study, the focus is on the meaning of the phenomenon under investigation for the research participants who participate in the study.

philanthropic: 'Loving one's fellow men, benevolent, humane' (Australian Concise Oxford Dictionary 1987).

philosophy (alternative view): 'A way of reflecting not so much on what is true and false but on our relationship to the truth' (Foucault, cited in Lotringer 1989).

philosophy/philosophic inquiry (conventional view): An argumentative intellectual discipline concerned with the discovery of 'truth' and meaning. Unlike science, which seeks answers to questions that can only be answered by empirical evidence, philosophy seeks answers to questions that cannot be answered by empirical evidence.

politics: The exercise and influence of power at both the micro and macro level.

population health: Population health has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

postmodernism: Relates to the critique of modern, capitalist, industrialised society; new political and social strategies, which embrace pluralism and diversity of cultures and values.

poststructuralism: Refers to a range of theoretical positions in which the mode of knowledge production uses particular theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change.

power: The capability and expertise to perform a task in an appropriate way. Professional power comes from the law, regulation, professional code of conduct, common practice and consent.

praxis: Praxis can be seen as the link between reflection and action. Friere (1972) defines praxis as 'reflection and action upon the world in order to transform it' (Cox et al 1991:385).

premise: A reason offered in support of a conclusion.

pre-reflection: Preparatory reflection that occurs before the experience.

preventive ethics: The study and practice of ethics (including ethics education) aimed at preventing (as opposed to remedying) moral problems.

primary healthcare: Primary healthcare encompasses a large range of providers and services across the public, private and non-government sectors. At a clinical level, it usually involves the first (primary) layer of services encountered in healthcare and requires teams of health professionals working together to provide comprehensive,

continuous and person-centred care. Primary healthcare providers include general practitioners, nurses, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers. Primary healthcare is the frontline of Australia's healthcare system. It can be provided in the home or in community-based settings (Australian Government Department of Health 2013).

professional development: Refers to skills and knowledge attained for both personal development and career advancement.

public health: 'The science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society' (WHO 1998:3).

qualitative research: Research that focuses on human experiences, including accounts of subjective realities, and conducted in naturalistic settings, involving close, often sustained contact between the researcher and research participants (Denzin & Lincoln 2005, Sarantakos 2005).

quantitative research: Refers to research that seeks to measure some concept or phenomenon of interest (e.g. blood pressure, pain or student attitudes to learning about research). It is also called positivist, reductionist or empirical. Quantitative research is termed deductive, which means the thinking leads from a known principle to an unknown, and is used to test a particular research hypothesis.

racism: A 'form of oppression/privilege which exists in a dialectical relationship with antiracism … societal system in which people are divided into races with power unevenly distributed, or produced based on their racial classification' (Paradies 2006:68).

rationalism: A philosophical position that argues that the only way to truth is through the deliberations of the rational human mind.

realism: An applied appreciation and acceptance of the authentic nature of the world, rather than an idealised view of it.

reflection (also reflection-on-action): Reflection that occurs after the experience.

reflective practice: The incorporation of reflection into practice.

regulatory authorities: Body responsible for regulating and maintaining the register of nurses.

relevance: A test applied to a premise or reason. If a premise or reason is relevant, it helps to support the conclusion of the argument.

science of nursing: Associated with technical capability and is underpinned by theories, concepts, models and frameworks. Scientific aspects of nursing help explain how to go about nursing relationships, the importance of the human health experience and contribute to nursing inquiry and evidence-based care.

self-awareness: Involves deliberately considering one's own values, beliefs and identity. This includes the ability to consider the values and beliefs of others.

shared governance: A concept based on the principles of partnership, equity,

accountability and ownership (Porter-O'Grady 1991). It requires health professionals to be self-directive, effective decision makers, strongly involved in the activities of the organisation at every level of participation, and providing clinical leadership (Porter-O'Grady 1991).

social capital: 'Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co-operation for mutual benefit' (WHO 1998:19).

social class: A broad concept encapsulating objective material, position and subjective understandings, and incorporating differing access to power (Walter & Saggers 2007:88).

social determinants of health: The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

social justice: 'Justice in terms of the distribution of wealth, opportunities, and privileges within a society' (English Oxford Living Dictionaries 2017).

social support: 'That assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life' (WHO 1998:20).

sound: An argument is sound when the premises are acceptable and provide adequate grounds for accepting the conclusion.

stereotype: A predetermined idea that ascribes particular characteristics to all members of a social group.

theory: A logically consistent set of propositions, which presents a systematic view of some aspect of reality.

theory–practice gap: Refers to the presence of lack in integration of theory into clinical practice which affects the patient care and satisfaction.

transformational leadership: A charismatic, motivating way of leading other individuals which generally comprises heightening followers' drive, satisfaction, confidence and bringing them together in the pursuit of mutual, challenging objectives, and altering their morals, beliefs and needs.

transition: A change from one form or type to another, or the process by which this happens.

unethical professional conduct: 'An umbrella term that incorporates the following three related although distinct notions: unethical conduct, moral incompetence and moral impairment' (Johnstone 2016:5).

universalism: Refers to the attributions of functions, social categories and activities to which women of all cultures are assigned; asserts what is shared in common by all

women.

validity: An argument is valid when the premises that are offered provide adequate grounds for acceptance of the conclusion.

whistleblowing: Disclosure of information and/or actions that are unethical or illegal, by an employee.

whole-of-world scenarios: Situations or a sequence of events that have or stand to have a global impact; that is, have an impact on the whole world, not merely local communities (e.g. climate change).

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